Report of the
Historical Institutional Abuse Inquiry

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The Inquiry Team

Chairman of the Inquiry

Sir Anthony Hart

Sir Anthony was called to the Northern Ireland Bar in September 1969, and to the Bar of England and Wales in 1975. He became a Queen's Counsel in 1983, and was appointed a county court judge in 1985. In 1997 he became the senior county court judge in Northern Ireland when he was appointed Recorder of Belfast, and in 2002 was the first person to be appointed as presiding judge of the County Courts in Northern Ireland. In January 2005 he was appointed a high court judge, and until his retirement in January 2012 was responsible to the Lord Chief Justice of Northern Ireland for the pre-trial hearings in, and listing of, all criminal cases heard by high court judges, and presided over many criminal trials.

Statutory Inquiry Panel Members

Geraldine Doherty

Geraldine qualified as a social worker in Belfast in 1979 and her first job was in residential child care in London. She has wide experience of social work, social care practice, education and training, working in England and Scotland. In 1996 she was appointed as the Head of the Central Council for Education and Training in Social Work in Scotland and in 2000 was seconded from that post to the Scottish Executive to advise on the establishment of national arrangements for the inspection and regulation of care services and the registration and regulation of social workers and social care workers. Geraldine was appointed in 2002 as the first Registrar of the Scottish Social Services Council (SSSC); all residential child care workers in Scotland must register with the SSSC, achieve relevant qualifications and abide by the SSSC Code of Practice.

David Lane CBE

David commenced his career with eight years in residential child care, working mainly in the assessment of young offenders, and he ended his career with eight years as Director of Social Services in the city of Wakefield. Since then he has been an independent consultant, and has prepared expert witness reports for over eighty cases in which former children in care have sought damages for negligence. He has played a major role in a number of professional organisations, and for over twelve years he has edited Children Webmag, a professional magazine for child care workers.

Acknowledgement Forum Panel Members

The Inquiry included a confidential Acknowledgement Forum in which victims and survivors could recount their childhood experiences of living in institutions to members of the Inquiry Panel. The Acknowledgement Forum Panel Members were:

Beverley Clarke

Beverley has wide experience of social work and child care, working in England and Canada. She is an independent expert witness and has worked for the Ministry of Justice and the Home Office.

Norah Gibbons

Norah was a Director of Advocacy in Barnardo's Ireland. She was also a Commissioner of the Ryan Inquiry into historical institutional abuse in Ireland.

Dave Marshall QPM

Dave is a consultant in the field of child safeguarding, investigation and management. For nine years he was Detective Chief Inspector and Head of the Metropolitan Police Child Abuse Investigation Command's Major Investigation Team.

Tom Shaw CBE

Tom was invited by Scottish Ministers to review the regulatory framework in Scotland designed to ensure the welfare needs and rights of Children in residential institutions from 1945-95. Subsequently he chaired 'Time to be Heard' – a pilot acknowledgement forum, for those who had experienced abuse in residential children's institutions in Scotland.

Secretary to the Inquiry

Andrew Browne

Andrew has been a member of the Northern Ireland Civil Service since 1980 and has served in a wide range of posts across four departments. He was Secretary to the Human Organs Inquiry and has assisted in setting up a number of public inquiries established by DHSSPS.

Solicitor to the Inquiry

Patrick Butler

Patrick was called to the Bar of Northern Ireland in 1998. He has previously worked for the Equality Commission and for the Departmental Solicitor's Office. Patrick has extensive experience of a number of legal areas including employment law, company law, judicial review and Parole Commissioners work.

Counsel to the Inquiry

Christine Smith - Senior Counsel

Christine Smith QC was appointed as Senior Counsel to the Inquiry. She was called to the Bar of Northern Ireland in 1985 and to the Bar of Ireland in 1996. She was appointed Queen's Counsel in 2011. Ms Smith has practiced in many areas of Law in Northern Ireland. Her most extensive experience is as Prosecuting Counsel, in which role she has had considerable experience in dealing with victims of sexual and physical abuse.

Joseph Aiken - Junior Counsel

Joseph Aiken was called to the Bar of Northern Ireland in 1999. Prior to taking up his role as Junior Counsel to the Inquiry he specialised in civil and commercial litigation, acting both for and against the Government. He has a particular interest in public inquiries, and has contributed to the leading textbook in the area, "Beer on Public Inquiries" published by Oxford University Press in 2011.

The Staff Team

Between April 2012 and January 2017 over 60 individuals worked in the Inquiry, and at its peak in January 2015 the team comprised 40 people, including the chairman, panel members, lawyers, the secretariat, witness support and the research team.

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Glossary

ACC	Assistant Chief Constable
ACF	Army Cadet Force
ACIC	Australian Catholic Immigration Committee
ADCI	Assistant Director and Coordinator of Intelligence (MI5)
ADD	Assistant Divisional Director (Barnardo's)
AIS	Army Information Service (HQNI)
APRU	Adolescent Psychology Research Unit
ASP	Assistant Secretary (Political)
'B' Specials	Ulster Special Constabulary
CARE	Child Abuse and Rape Enquiry Unit
CCETSW	Central Council for Education and Training in Social Work
CCWC	Catholic Child Welfare Committees (also refers to the Catholic Child Welfare Council)
CGS	Chief of the General Staff (British Army)
CHIS	Covert Human Intelligence Source
CID	Criminal Investigation Department
CIO	Chief Information Officer
CLF	Commander Land Forces
CMT	Child Migrants Trust
CO	Commanding Officer
COSICA	Commissioner for Survivors of Institutional Childhood Abuse
CQSW	Certificate of Qualification in Social Work
CRCC (YP)	Certificate in Residential Care of Children (and Young People)
CSAB	Civil Service Appeal Board
CSS	Certificate in Social Services
CWC	Child Welfare Council
CWO	County Welfare Officer
CYP/A 1950	Children and Young Persons Act (Northern Ireland) 1950
DC	Detective Constable
DCI	Director and Co-ordinator of Intelligence
DHSB	Deputy Head of Special Branch

DHSS	Department of Health and Social Services
DHSSPS	Department of Health, Social Services and Public Safety
D/Insp	Detective Inspector
DoH	Department of Health
DoJ	Department of Justice
DPP	Director of Public Prosecutions
D/S	Detective Sergeant
D/Supt	Detective Superintendent
EHSSB	Eastern Health and Social Services Board
ESN	Educationally Sub-Normal
GOC (NI)	General Officer Commanding (Northern Ireland)
GSC	General Service Corps
GSO I	General Staff Officer One
HIA	Historical Institutional Abuse (Inquiry)
HMCIP	Her Majesty's Chief Inspector of Prisons for England and Wales
HMRC	Her Majesty's Revenue and Customs
HMSO	Her Majesty's Stationery Office
HQNI	British Army Headquarters Northern Ireland (Thiepval Barracks)
HSB	Head of Special Branch
HSCB	Health and Social Care Board
ICM	Irish Church Missions
ICU	Intensive Care Unit
IJS	Irish Joint Section (MI5/SIS)
IO	Intelligence Officer
IP	Information Policy (Military unit at HQNI)
IR	Independent Representatives (NIACRO)
IRA	Irish Republican Army (can refer to Provisional IRA or Official IRA)
IRD	Information Research Department (Foreign and Commonwealth Office)
JIC	Joint Intelligence Committee
KBH	Kincora Boys' Home
MI5	Military Intelligence, Section 5 (Security Service)

MI6	Military Intelligence, Section 6 (Secret Intelligence Service)
MIO	Military Intelligence Officer
MISR	Military Intelligence Source Report
MoD	Ministry of Defence
MoHA	Ministry of Home Affairs
NAA	National Archives of Australia
NCO	Non-commissioned Officer
NIACRO	Northern Ireland Association for the Care and Resettlement of Offenders
NIO	Northern Ireland Office
NIPSA	Northern Ireland Public Service Alliance
OC	Officer Commanding
OFMDFM	Office of the First Minister and Deputy First Minister
PACE	Police and Criminal Evidence (Northern Ireland) Order (1989)
PARR	Proposals for the Allocation of Revenue Resources for Health and Social Services
PES	Public Expenditure Survey
PHAB	Physically Handicapped and Able Bodied
PIRA	Provisional Irish Republican Army
PRONI	Public Record Office of Northern Ireland
PSNI	Police Service of Northern Ireland
PSS	Personal Social Services
PSSC	Personal Social Services Committee
RAWP	Resource Allocation Working Party
RC	Roman Catholic
RCCE	Revenue Consequences of Capital Expenditure
RQIA	Regulation and Quality Improvement Authority
RUC	Royal Ulster Constabulary
SAS	Special Air Service
SEHSCT	South Eastern Health and Social Care Trust
SHSSB	Southern Health and Social Services Board
SIB	Army Special Investigation Branch
SIO	Senior Intelligence Officer

SIS	Secret Intelligence Service
SMR	Standardised Mortality Rates
SPG	Special Patrol Group (RUC)
SSI	Social Services Inspectorate
SWAG	Social Work Advisory Group
TAVR	Territorial Army Volunteer Reserve
TWC	Tyrone Welfare Committee
UDA	Ulster Defence Association
UDR	Ulster Defence Regiment
ULA	Ulster Loyalist Association
UVF	Ulster Volunteer Force
UWC	Ulster Workers' Council
WHSCT	Western Health and Social Care Trust
WHSSB	Western Health and Social Services Board
WSO	Witness Support Officer
YOC	Young Offender Centre

HIA Designations

AU	Child Migrant Programme (Australia)
B	A designation from the Hughes Inquiry (1985 Report of the Committee of Inquiry into Children's Homes and Hostels, referred to in Module 15 hearings) for an individual who gave evidence regarding Bawnmore
BAR	A witness who can provide evidence in relation to a Barnardo's institution (Macedon, Sharonmore)
BAU	A Brother who worked in an institution under investigation or who belonged to the Order concerned in Australia
BM	A witness who can provide evidence in relation to Bawnmore Children's Home
BP	De La Salle Brother (Provincial)
BR	A Brother who worked in an institution under investigation or who belonged to the Order concerned
DL	De La Salle
FBS	Father Brendan Smyth
FJ	A witness who can provide evidence in relation to Fort James Children's Home
GOV	Officials referred to in Governance statements
HB	Hydebank Young Offenders Centre
HH	A witness who can provide evidence in relation to Harberton House Assessment Centre
HIA	A witness who was resident in an institution and has given evidence to Inquiry
KIN	A witness who can provide evidence in relation to Kincora Boys' Home
LN	A witness who can provide evidence in relation to Lisnevin Training School
LS/LIS	A witness who can provide evidence in relation to Lissue Hospital
MG	Magilligan Borstal Unit
MH	A witness who can provide evidence in relation to Manor House
MZ	Maze Prison Borstal Wing/Department of Justice witness (for Module 10 – Millisle Borstal)

NL	A witness who can provide evidence in relation to Nazareth Lodge
NHB	A witness who can provide evidence in relation to Nazareth House Belfast
OV	Outside visitor (to Kincora)
PM	Palmerston Assessment Centre
R	A designation from the Hughes Inquiry (1985 Report of the Committee of Inquiry into Children's Homes and Hostels, referred to in Module 15 hearings) who gave evidence regarding Kincora
RG	A witness who can provide evidence in relation to Rathgael Training School
SAU	A Sister who worked in an institution under investigation or who belonged to the Order concerned in Australia
SJM	A Witness who can provide evidence in relation to St. Joseph's Training School, Middletown
SND	Any other person associated with the Sisters of Nazareth, Derry/ Londonderry including staff but not the Sisters themselves
SOM	Sisters of Mercy
SPT	A witness who can provide evidence in relation to St Patrick's Training School
SR	A Sister who worked in an institution under investigation or who belonged to the Order concerned
TL	Any person associated with Tara Lodge, including staff
XY	Miscellaneous

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Chapter 1:

Introduction

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Part One

1 On 29 September 2011 the Northern Ireland Executive announced that it intended to set up an Inquiry into abuse in residential homes in Northern Ireland, and on 31 May 2012 the First Minister and deputy First Minister announced the agreed Terms of Reference for the Historical Institutional Abuse Inquiry (the HIA Inquiry) and advised the Northern Ireland Assembly of the appointment of the Chairman of the Inquiry and the panel members for the Acknowledgement Forum.

2 The Terms of Reference originally provided that the HIA Inquiry would examine the period between 1945 and 1995. Representations were made to the First Minster and deputy First Minister that the start date of 1945 would result in the exclusion from the Inquiry of a number of those who were resident in residential institutions within the Inquiry's Terms of Reference before 1945, and so the remit of the Inquiry should be extended. After consultation with the Chairman of the Inquiry, the First Minister and deputy First Minister announced that the Terms of Reference would be amended to extend the ambit of the Inquiry to start in 1922 and to finish in 1995.

3 During the early stages of the HIA Inquiry's public hearings in 2014 it became apparent that it would not be possible for the Inquiry to hear oral evidence from every applicant unless the Terms of Reference were extended to give the Inquiry an extra year to complete its work. The Inquiry therefore applied to the First Minister and deputy First Minister to grant an extension of an extra year to the Inquiry. The First and deputy First Minister agreed to the application, and the Terms of Reference of the Inquiry were formally amended by The Inquiry into Historical Institutional Abuse (Amendment of Terms of Reference) Order (Northern Ireland) 2015, which came into operation on 11 February 2015.

4 The effect of this amendment was that the three year period given to the Inquiry to carry out its investigations and deliver its Report was extended to four years from 19 January 2013, three and a half years of which was to allow the Inquiry to conduct its public hearings and investigations, and a further six months to deliver its report.

The Acknowledgement Forum

5 The Terms of Reference provided for a separate Acknowledgement Forum to

> "... provide a place where victims and survivors can recount their experiences within institutions. A 4 person panel will be appointed by the First Minister and deputy First Minister to lead this forum. This Forum will provide an opportunity for victims and survivors to recount their experience on a confidential basis. A report will be brought forward by the panel outlining the experiences of the victims and survivors. All records will be destroyed after the Inquiry is concluded. The records will not be used for any other purpose than that for which they were intended. If necessary the Forum will have the authority to hear accounts from individuals whose experiences fell outside the period 1922 – 1995. The Acknowledgement Forum will operate as a separate body within the Inquiry and Investigation accountable to and under the chairmanship of the Inquiry and Investigation Panel Chair."

6 As the Terms of Reference made clear, the Acknowledgement Forum provided an opportunity for applicants to the Inquiry to recount their experiences of their time as children in residential homes within the Inquiry's Terms of Reference on a confidential basis. The panel members almost always sat in teams of two, and their role was to enable applicants to the Acknowledgement Forum to describe their experiences in a completely confidential setting. The function of the Acknowledgment Forum was not to interrogate or question the applicants about their experiences, although where necessary panel members asked questions in order to help the applicant to describe his or her experiences. Because the Inquiry and the Acknowledgement Forum recognised that this could be a very difficult experience for applicants, an applicant could, if he or she wished, be accompanied by a companion of their choice whilst they recounted their experiences.

7 As the Acknowledgment Forum did not require statutory authority to carry out its work, the Inquiry devoted its initial efforts to putting in place the necessary administrative staff and processes to enable the Acknowledgement Forum to start its work as soon as possible. By a public notice of 1 October 2012 applications were invited from those who wished to speak to the Acknowledgement Forum, and the first interviews were conducted by the Acknowledgment Forum on 22 October 2012.

8 Altogether the Acknowledgment Forum heard from 428 applicants between 22 October 2012 and the completion of their hearings in November 2014. Most of the applicants spoke to the Acknowledgment Forum at various locations in Northern Ireland. Whilst interviews were conducted by the Acknowledgment Forum in the Inquiry Headquarters in Belfast, many interviews took place in Derry/Londonderry (names that we use interchangeably throughout this Report) and other locations throughout Northern Ireland, in the Republic of Ireland, in Great Britain and in Australia. Apart from those applicants who gave evidence by live link from Canada and the United States, all the meetings were conducted on a face-to-face basis. Although the great majority of meetings which took place outside the Inquiry's Headquarters in Belfast took place in hotel rooms rented by the Inquiry for that purpose, there were a number of occasions when Acknowledgement Forum panel members spoke to applicants in prison or in the applicant's home.

9 Although the Inquiry made it quite clear that the Acknowledgement Forum was a confidential process that was never intended to be used as a vehicle for gathering evidence for civil proceedings, there were applications to the Inquiry by solicitors representing applicants who sought access to the transcripts of the meetings in order to gather evidence for civil proceedings. The Inquiry declined to produce such transcripts and its position was upheld by the High Court, and on appeal by the Court of Appeal in LP's Application [2014] NICA 67. As Lord Justice Gillen explained when giving the judgment of the Court of Appeal at [35]

> "The AF is a unique provision. It is intended to operate as a confidential and private service where victims and survivors can recount their experience of their time in institutional care with total confidence in the integrity and confidentiality of that stage of the process... It is vital to the integrity of the Inquiry to ensure that there is a public perception that this will remain the case. The grim truth is that if it were to become common place for such recordings to be provided, with all the attendant risks of such material innocently or otherwise getting into the public domain, we can readily see the deleterious effect this might have on the process as a whole."

And at [36]

> "The record of the AF process is not to be used for any purpose other than those for which it was intended. For example it was never intended that it was to be used as a vehicle for gathering evidence for civil proceedings."

10 In order to allow as many as possible to apply to the Acknowledgement Forum it was not until 6 March 2014 that the Inquiry announced that the closing date for such applications would be Wednesday 30 April 2014.

The Statutory Inquiry

11 The Inquiry Terms of Reference also provided for "An Inquiry and Investigation Panel" with the task of producing "a final report taking into consideration the report from the Acknowledgement Forum, the Report of the Research and Investigative team and any other evidence it considers necessary."

12 For convenience we describe the Inquiry and Investigation Panel as the "Statutory Inquiry" or "The Inquiry", and when we refer to the Statutory Inquiry or to The Inquiry in this Report this is a reference to the Investigation and Inquiry Panel.

13 Unlike the Acknowledgment Forum, the Statutory Inquiry was created by, and operated under, the provisions of, an Act of the Northern Ireland Assembly. On 12 June 2012 the Inquiry into Historical Institutional Abuse Bill was laid before the Assembly. The Bill passed through a number of stages and was passed by the Assembly on 11 December 2012, and following Royal Assent the Inquiry into Historical Institutional Abuse Act (Northern Ireland) 2013 (the 2013 Act) became law on 19 January 2013. Statutory Rules made under Section 21 of the 2013 Act were laid before the Assembly on 24 June 2013 and took effect from 25 July 2013.

14 In order to provide for various procedures relating to the operation of the Statutory Inquiry the Chairman published three protocols.

1 A Procedural Protocol

2 A Cost Protocol

3 A Redaction, Anonymity and Restriction Orders Protocol

Under the Redaction, Anonymity and Restriction Orders Protocol the Chairman subsequently made seven Restriction Orders. The Protocols, and the Restriction Orders, can be found on the Inquiry's website.

15 The Inquiry also published guidelines and other relevant procedural documents. These included the definition of abuse used by the Inquiry, undertakings given by the Director of Public Prosecutions for Northern Ireland and the Attorney General for England and Wales in respect of witnesses providing evidence to the Inquiry, application forms for grants of

legal representation by the Inquiry at public expense, and a template to be used by legal representatives submitting an invoice for payment of costs awarded by the Inquiry.

16 The Inquiry was not provided with a definition of "abuse" by the Terms of Reference and we therefore adopted the following definition, which recognised that abuse could take the form of sexual abuse, physical abuse, emotional abuse, neglect or unacceptable practices which were against the interest of the children. We set out the full definition of abuse and systemic failings in Appendix 1 to this chapter, and it is sufficient for present purposes to set out paragraph four of the definition.

> ""Abuse" was behaviour which either (a) involved improper sexual or physical behaviour by an adult with another child towards a child; or (b) in the case of emotional abuse, was improper behaviour by an adult or another child to undermine a child's self-esteem and emotional well-being, such as bullying, belittling or humiliating a child; or (c) resulted in neglect of the child; or (d) took the form of adopting or accepting policies and practices, such as numbering children or ignoring or undermining sibling relationships, which ignored the interest of the children."

The research and investigative team

17 In our work the Inquiry was greatly assisted by the work of the researchers in our Research and Investigative Team. Before and during the public hearings they were embedded in the Public Record Office of Northern Ireland (PRONI) where they worked in close conjunction with the Inquiry legal team and PRONI staff. Their excellent working relationship with PRONI meant they were able to trace and examine huge numbers of departmental files, as well as files deposited by former public bodies such as welfare authorities. In several instances it was due to their researches that the Inquiry decided to investigate a particular institution or topic. In the future other inquiries of a similar type might well find that embedding their research staff in PRONI in this way would be valuable.

Applications

18 From the beginning of our work the Inquiry realised that it was necessary to publicise our work as widely as possible so that as many of those who might be able to assist our work would be aware of our existence and would come forward to describe their experiences so that we would gather

as large a volume of evidence of experiences as possible. We organised a poster campaign at sites throughout Northern Ireland in February 2013. Rather than engage in conventional and costly newspaper advertising we decided to utilise other means to reach those who we felt would be able to assist us. The Chairman, Secretary and members of the Acknowledgement Forum made themselves available for press, radio and television interviews, including interviews given to radio stations in Australia and New Zealand.

19 The Inquiry also contacted a very large number of organisations throughout the rest of the United Kingdom, in North America and in Australia, which provide various means of contact for people who emigrated from Northern Ireland. These organisations were extremely helpful in publicising our existence and making material available through their websites, newsletters and other means of communication, and we are very grateful to them.

20 The Chairman also wrote to the leaders of the four main Christian denominations in Northern Ireland and the Republic of Ireland asking them to publicise the Inquiry's material through their respective church structures and publications. We are grateful to them, to the media and to the many organisations that helped publicised our existence.

Number of applicants

21 Altogether 526 individuals applied to the Inquiry and the Acknowledgement Forum. The total of 526 includes two late applications that were admitted by the Inquiry, but excludes seven duplicates received in cases where an application had already been made.

22 Not all those who applied were within the Inquiry's Terms of Reference. Also a number of those who applied to the Inquiry subsequently withdrew their applications. Others did not maintain contact with the Inquiry. Despite a number of reminders by the Inquiry, fourteen did not continue to engage with us. In each of the fourteen cases the Inquiry closed the file, but was prepared to reopen it if the applicant subsequently wished to re-engage with us. Consequently, when duplicates and those outside our Terms of Reference are excluded, 493 individuals engaged with the Inquiry as applicants.

23 As the table below indicates, of the applicants who were within our Terms of Reference, 62.5% of applicants lived in Northern Ireland, of whom 22.1% lived in Belfast and 40.4% in other parts of Northern Ireland (approximately 12% of these lived in the North West of the province).

Location of Applicants*

Location	No.	%
Belfast	109	22.1
NI outside Belfast	199	40.4
ROI	22	4.5
Scotland	7	1.4
Wales	2	0.4
England	82	16.6
Europe	5	1.0
USA Canada	4	0.8
Australia	63	12.8
Total	**493**	**100**

* These figures do not include applications which were duplicates or were outside the Inquiry Terms of Reference.

As can be seen from the table below, 31% of applicants were age between 55 and 64, 24% were age between 65 and 74 and 10% were over 75.

Age Profile of Applicants*

Age band	No.	%
Up to 34	3	1
35-44	49	10
45-54	120	24
55-64	155	31
65- 74	118	24
75+	48	10
Total	**493**	**100**

* These figures do not include applications which were duplicates or were outside the Inquiry Terms of Reference.

Assistance to applicants

24 From the beginning, the Inquiry was acutely aware of the need to make the process of engaging with the Inquiry as straightforward as possible for those who wished to tell us of their experiences as children in residential homes or other institutions within our Terms of Reference. We made considerable efforts to reduce the amount of distress or strain experienced by those who wished to tell us about their experiences. We appointed a number of Witness Support Officers (WSOs) whose task it was to act as the point of contact for an individual applicant with the Inquiry. The intention was that each applicant would, wherever possible, deal with the same WSO when arrangements had to be made to speak to the Inquiry, whether that involved coming to speak to the Acknowledgement Forum, speaking to the Inquiry legal team or to give evidence during the hearings which were held at Banbridge.

25 Because we recognised how upsetting it could be for many of those who wished to describe their experiences to us we informed every applicant that, if they wished, they could be accompanied by a companion of his or her choosing when they spoke to the Inquiry, whether that was to the Acknowledgement Forum, during meetings with the legal team, and before giving evidence or while they were giving evidence in the Inquiry chamber. We also paid their travel, accommodation and other costs where necessary. The Inquiry paid approximately £145,000 for the travel, accommodation and subsistence of 320 individuals who travelled from all over the United Kingdom, from the Republic of Ireland, and from elsewhere in Europe in some instances. This included the cost of travel, accommodation and subsistence for those who travelled to various centres in Australia to meet the members of the Acknowledgment Forum, our Legal Team and Witness Support Officers who went to Australia in September and October 2013, and again in June and early July 2014, to talk to applicants living in Western Australia and other parts of Australia.

26 When it came to the time when individuals who wished to speak to the Statutory Inquiry during our hearings in Banbridge came to give evidence, in addition to providing them with the services of our Witness Support Officers, the Inquiry arranged to have a representative from Contact NI present in the Inquiry chamber in order to provide immediate comfort and reassurance to anyone who found the experience so upsetting that they felt the need for immediate assistance.

27 Throughout the life of the Inquiry we provided information to all applicants to help them contact the appropriate agency if they found the experience of recounting their experience to, or engaging with, the Inquiry to be stressful or distressing.

The form of the hearings

28 It was central to our work that the Inquiry hearings were conducted in an inquisitorial fashion by Inquiry Counsel taking each witness through their evidence, whether that person was an applicant to the Inquiry or a witness called by the Inquiry, including witnesses from the institution under examination at the time or giving evidence on behalf of, or in respect of, issues that the Inquiry was investigating. The inquisitorial approach meant that each witness was able to give his or her evidence, and for that evidence to be thoroughly probed in an appropriate fashion, without the witness being subjected to inappropriate or unnecessary cross examination.

29 This did not mean that their evidence was taken at face value without being thoroughly probed and investigated. On the contrary, Inquiry Counsel and the Inquiry legal team went to great lengths to ensure that all relevant material was drawn to the attention of the Inquiry Panel and put to each witness. That was the case whether the material was supportive of, or undermined to some degree, the account given by the witness, whether the witness was describing his or her experiences, or speaking on behalf of an institution or organisation. As part of this process the legal representatives of the core participants and individuals, and their representatives where a core participant chose not to be legally represented, asked Inquiry Counsel to put additional points to each witness. Inquiry Counsel then raised the point with the witness in an appropriate fashion.

30 A public inquiry is obliged to ensure that the matters which it is considering are examined by it in an independent and thorough fashion. This means that the accounts given to it by organisations and individuals must be thoroughly probed and objectively assessed, whether the evidence comes from an applicant to the Inquiry or comes from the person against whom allegations of abuse, or some other failing, are levelled. Some applicants found it very difficult to accept that this process necessarily involved the views of institutions or individuals being put to them and their then being asked to comment upon whatever contrary view was being put forward. The Inquiry went to considerable lengths to ensure that all who appeared

before it received a calm and sympathetic, but objective, assessment and appraisal of their evidence. This process was greatly assisted by the skilful way in which Inquiry Counsel took all witnesses through their evidence in a sympathetic fashion, whilst still putting to them politely and firmly relevant matters that might be seen by the witness concerned to imply that their recollection was inaccurate in some respect.

Gathering documents and evidence

31 Using its powers under section 9 of the 2013 Act the Inquiry issued notices to each core participant, and to individuals as necessary, requiring them to provide documents and witness statements, and to give evidence where appropriate. As a result of notices issued to institutions which were designated by the Inquiry as core participants, and to the PSNI, the Inquiry gathered a very large number of documents from various sources, including documents deposited with the Public Record Office of Northern Ireland (PRONI). Altogether 355,891 pages were included in the evidence bundles for the fifteen Modules into which the inquiry divided its public hearings. This was only a proportion of the total number of documents submitted to the Inquiry, and represented the documents which the Inquiry believed it should make available as necessary to witnesses and core participants to enable them to assist the Inquiry. The volume of material meant it was a laborious and time-consuming task for the Inquiry legal team to collate and analyse the documents in order to decide what needed to be examined in the public hearings.

32 We were well aware that many applicants would find it extremely distressing if their experiences, whether described in public to the Inquiry, or in confidence to the Acknowledgement Forum, were attributed to them by name. Many had never disclosed their experiences to anyone, or only to some, but not all, of their families. We believed that if such individuals were to be publicly identified by name this would act as a considerable deterrent to witnesses coming forward to assist the Inquiry. Some of those who came forward as applicants were themselves the subject of allegations by other applicants that they had also abused applicants whilst resident in institutions within our Terms of Reference. Some of those against whom allegations were made were either dead or in poor physical or mental condition and therefore unable to give evidence on their own behalf in response to the allegations.

33 We wish to acknowledge the willingness to answer our requests shown by all the core participants and other institutions or bodies who were asked to produce documents, and to trace witnesses, by the Inquiry, whether these were non-devolved departments and agencies; religious bodies such as Roman Catholic dioceses and religious orders, or the Police Service of Northern Ireland to name only some of those who helped us. We were well aware that our requests to trace documents, and identify whether possible witnesses were still alive and able to help us, imposed considerable burdens on institutions and other bodies, and their legal representatives. Their co-operation meant that we were able to obtain many important documents whose very existence and significance was hitherto unknown.

34 As our Terms of Reference covered 73 years many relevant bodies ceased to exist, or their names and functions were changed, sometimes radically. As a result it is not always easy to trace the successor body, if there was one. Particularly after the Macrory reforms of the 1970s there were significant changes to the structure of both local and central government, and to the names of bodies concerned with matters within our Terms of Reference. Thus the county welfare authorities were replaced by the health and social services boards, which then were replaced by a single board and fewer health and social care trusts. During the Inquiry itself, the Department of Health, Social Services and Public Safety (DHSSPS) became the Department of Health (DoH).

35 We decided that the majority of those who were describing their experiences, and those against whom allegations were made, should therefore be given designations to protect their anonymity. Core participants and relevant witnesses were made aware of the identity of the person to whom the designation was given so that the institution or individual could respond to what that person was saying as necessary. It was always open to an individual to waive that anonymity if they wished to do so, and whilst a minority waived their anonymity the great majority wished to retain their anonymity. Those witnesses and others who did not waive their anonymity were, and will continue to be, protected by the anonymity conferred upon them by the Inquiry.

36 The Inquiry held 223 days of hearings at Banbridge Courthouse, almost all of which were held in public. Eighteen hearings in 2014 and 2015 took the form of closed hearings solely to avoid prejudice to criminal trials that were imminent at that time. Transcripts of the proceedings during the remaining days have been placed on the Inquiry website, although they

have been redacted as necessary to comply with the Inquiry's anonymity and redaction procedures. In the same way, the documents brought up during the Inquiry hearings and publicly displayed in the Inquiry Chamber have been, or in due course will be, placed on the Inquiry website, although those documents will also be redacted as necessary to comply with the Inquiry's anonymity and redaction processes. The redaction process of those documents has proved to be more complex and time consuming than anticipated, and so not all documents will have been placed on the Inquiry website by the time this Report is published. The remainder will be placed on the website in due course.

Assessment of evidence

37 As will be apparent from the Terms of Reference which required the Inquiry to examine residential institutions for children over a period of 73 years between 1922 and 1995, many of those who gave evidence to us, whether as applicants or other witnesses, were being asked to describe events that occurred many decades in the past, most were being asked to recall events between 30 and 60 years ago, and some events more than 70 years ago. The passage of time naturally created considerable difficulties for many of those who were asked to recall events that occurred so long ago. Some of those against whom allegations were made were dead, others were too physically frail to give evidence in person, or their mental health or memory had failed to such a degree that they were not able to give reliable evidence. Where medical evidence was produced on behalf of a witness the Inquiry considered that evidence. If we were satisfied the witness was unfit to provide a statement, or to attend to give evidence in person, their statement was admitted without them giving evidence in person, or they were excused from providing evidence to the Inquiry. For example, in the case of HIA 128 where the Inquiry was satisfied that he was extremely vulnerable, very suggestible and would have difficulty in answering questions, the Inquiry felt it was inappropriate to put him through the ordeal of giving evidence and his statement was read and noted by the Inquiry.

38 The Inquiry was well aware that the passage of time may render recollections inaccurate, or those recollections may be coloured to a greater or lesser degree by discussions with others, or by accounts that the individual has been made aware of in later years. Another factor was that adults describing events which occurred when they were children may not always

have appreciated at the time all of the relevant circumstances surrounding the actions of the adults, such as the post-war shortages of food and other items that may have affected the way in which they were looked after as children. Equally, events that may seem routine at the time, and hence not memorable, may be forgotten in adult life, such as routine trips to see a doctor or a dentist. In contrast, despite the passage of very long periods of time, some events may have been of such significance at the time that they can be vividly and accurately recalled many years later, for example where a child was repeatedly beaten in front of others or humiliated in front of others for some reason, such as being made to carry wet bed sheets past others to a laundry when they had wet the bed.

39 Where contemporary documents and records survived, and many records had either not been compiled in the first place, or had long since been disposed of by institutions and government departments and agencies as the result of normal document disposal procedures, the documents often threw light on the recollections of those who were being asked to recall events of many years before. The collection of documents, and analysis of their content, was therefore central to our work. All those institutions and organisations who were asked to produce documents went to great lengths to comply with our requests. We recognise that this meant the expenditure of a great deal of time and effort, and consequent expense, on the part of those who received such requests and we are very grateful for their co-operation.

Role of the Inquiry

40 The Inquiry was not a court and was expressly precluded by Section 1 (5) of the 2013 Act from (a) ruling upon, or (b) determining, any person's civil or criminal liability. This meant the Inquiry could not make a finding that rendered an individual or an institution guilty of a criminal offence, or subject to civil liability. That is the responsibility of the civil and criminal courts. However, this does not mean that the Inquiry could not identify acts or omissions which, if the same evidence were given in civil or criminal proceedings, might result in the award of damages or some other remedy, or a conviction. If the Inquiry could not make such findings it would be severely hampered in performing the task imposed upon it by its Terms of Reference within the statutory framework created by the legislature.

41 The Terms of Reference of our Inquiry required us to identify whether there were systemic failings on the part of an institution, which meant any body,

society or organisation with responsibility for the care, health or welfare of children in Northern Ireland which provided residential accommodation and took decisions about and made provision for the day-to-day care of children under 18 between 1922 and 1995. Conclusions as to whether or not systemic failings existed can only be made once the Inquiry has identified acts or omissions that could be considered to amount to a systemic failing on the part of the institution, body or individual concerned. For example, if A says he or she was physically or sexually assaulted by B, it is necessary to decide whether or not that happened. Only if the Inquiry is satisfied that there was a relevant act or omission on the part of an individual or an organisation can the Inquiry then proceed to consider whether, in those circumstances, and in the light of that finding, there was a systemic failing on the part of the body or institution concerned.

42 In general the Inquiry sought to avoid reaching conclusions of fact in relation to specific acts or identifiable individuals where it was possible to arrive at conclusions as to systemic failings without identifying an individual or a specific incident. For example, if ten individuals alleged that one person assaulted them in some way, and if the Inquiry was satisfied that some of those allegations were credible then it was unnecessary for us to specify which of the accounts were reliable and which were not. However, there were a small number of situations where the Inquiry had to identify whether a specific individual did or did not do something in order to determine whether or not there was a systemic failing. If, for example, an individual was alleged to have repeatedly committed sexual offences against children in his or her care, the Inquiry had to reach a view as to whether or not those events occurred in order to determine whether or not there was a systemic failing by an individual or an institution.

Standard of proof

43 The 2013 Act is silent as to the standard of proof to be applied by the Inquiry when reaching our findings. The 2013 Act mirrors the provisions of the Inquiries Act 2005, and the standard of proof to be adopted by inquiries under the 2005 Act and other types of inquiry has been considered on several occasions in recent years. We do not consider it necessary to engage in a review of these authorities because we adopt the approach identified by Sir William Gage in the *Baha Mousa* Inquiry where he explained that he was not obliged to adopt the criminal standard of proof, that is proof beyond reasonable doubt. He concluded:

> "In order properly to report who is responsible, in my judgment, I must reserve to myself the right to state, were I find the evidence sufficient, that I find a fact proved on a balance of probabilities. To do otherwise would necessarily be to limit my findings of responsibility to the high criminal standards."

We have applied the same test to the evidence before us and in our assessment of the evidence.

The standards against which historic practices should be compared

44 Our Inquiry was obliged to consider matters stretching over many decades. Over that period of time there have been changes in what is regarded as acceptable or unacceptable behaviour towards children, and in what are regarded as proper standards of accommodation and childcare for children in residential care. If we were to judge what happened many years ago by the standards of today that would mean imposing today's standards on the past with the advantage of hindsight. We did not consider that that was the correct approach to take. Throughout, we approached the evidence we heard on the basis of what we believed to be the appropriate standards of care that should have been applied by the residential institution at the time we were considering. That required us to take into account the economic and social circumstances at the time, the level of professional training and competence to be expected at the time, and other relevant factors that related to the period under consideration.

Part Two

45 When deciding which institutions to examine we took into account a number of factors. The first was the number of applicants who complained about an institution. The second was the nature of the complaints, and the third was the type of institution. As will be apparent from the various chapters, the largest numbers of applicants wished to speak about their experiences when in four homes run by the Sisters of Nazareth, the next largest number being those who wished to describe their experiences in Rubane House or in St Patrick's Training School, both of which were run by the De La Salle Order. We decided to investigate the following homes.

Local Authority Homes

Lissue Hospital, Lisburn
Kincora Boys' Home, Belfast
Bawnmore Children's Home, Newtownabbey
Fort James, Londonderry
Harberton House, Londonderry

Juvenile Justice Institutions

St Patrick's Training School, Belfast
Lisnevin Training School, Newtownards, County Down
Rathgael Training School, Bangor
Hydebank Young Offenders' Centre
Millisle Borstal

Secular Voluntary Homes

Barnardo's Sharonmore Project, Newtownabbey
Barnardo's Macedon, Newtownabbey

Roman Catholic Voluntary Homes

St Joseph's Home, Termonbacca, Londonderry
Nazareth House Children's Home, Londonderry
Nazareth House Children's Home, Belfast
Nazareth Lodge Children's Home, Belfast
De La Salle Boys' Home, Rubane House, Kircubbin
St Joseph's Training School for Girls, Middletown, Co Armagh
Three institutions run by the Good Shepherd Sisters in Derry/Londonderry, Belfast and Newry

Church of Ireland

Manor House, a children's home near Lisburn.

46 We carefully reviewed every one of the remaining homes and institutions in respect of which an individual made a complaint to see whether or not a full public investigation of the type we conducted in respect of the above homes and institutions was absolutely necessary to add further information to the picture of the nature and extent of systemic failings on the part of the homes and institutions, and on the part of the state, that emerged based on the evidence we received from our investigations into the other homes and institutions. We decided that an examination of the homes and institutions listed above was sufficient to provide the Inquiry with a broad and complete understanding of the nature and extent of systemic failings, not just in those homes and institutions, but within all the types of homes and institutions that were within our remit. This was because we believed that our understanding of the nature and extent of the abuse, and of the systemic failings that allowed abuse to happen, would not be improved by conducting full scale investigations into other homes and institutions. There was no home omitted from our investigations in respect of which there was a substantial number of complainants.

47 We conducted a small number of targeted paper investigations into six homes or institutions in respect of which there were complaints by individual applicants which we felt required further examination. When considering which homes should be the subject of investigation requiring full documentation and oral hearings, it became apparent that there were some homes where there were specific causes of concern such as serious incidents, possible systemic failings or the actions of a member of staff which warranted targeted paper-based investigations without taking into account the whole of the homes' histories and functioning. Targeted investigations were undertaken concerning individual allegations relating to five homes and one hospital. We have made no finding of systemic abuse or failure in relation to any of the six establishments.

48 Altogether applicants made allegations of some form of abuse in respect of 65 institutions or homes. We investigated twenty two in our public hearings, and a further six were the subject of targeted paper investigations, making twenty eight institutions or homes we investigated in all. The remaining thirty seven institutions or homes were each the subject of allegations by two applicants at most, and in some case by only one applicant. In each of the thirty seven remaining cases the panel considered the statements and/or accounts given by each applicant. Having done so we decided that our understanding of the nature and extent of the abuse, and of the systemic

failings that allowed abuse to happen, within all the types of homes and institutions within our remit would not be improved by conducting full scale investigations into any of those thirty seven homes and institutions. As the Chairman emphasised in his remarks of 4 November 2015, this did not mean that we had decided that abuse did not occur in those homes or institutions, nor did it have any effect on our recommendations for compensation and other forms of redress that we make in Chapter 4.

49 There were also further homes which we considered where applicants had lived but about which they had made no, or minimal, complaints, and which did not merit any investigation by us.

Reports to the police

50 Almost all of the allegations made by applicants to the Inquiry were capable of amounting to criminal offences if they were substantiated. We referred each such complaint to the relevant police force for investigation, and in almost all cases this was the PSNI. In a few cases where the complaint was made by or about a person living elsewhere in the United Kingdom the matter was referred to the appropriate force.

Other investigations

51 We also conducted investigations into two issues that became apparent at an early stage of our evidence gathering. The first was that a large number of children were sent to Australia as part of what was called the Child Migrants Programme or Child Migrants Scheme. Many of the applicants who were sent to Australia as children complained that this was itself abusive. The second was into the allegations that Fr Brendan Smyth sexually abused children who were in residential children's homes in Northern Ireland that were within our Terms of Reference.

Kincora and the non-devolved Departments and Agencies

52 As we explain in Volume 8 Chapter 25 the Inquiry agreed to the request by the Secretary of State for Northern Ireland to include in our investigations the allegations relating to Kincora and the non-devolved departments and agencies which are the constitutional and legal responsibility of Her Majesty's Government and not the responsibility of the Northern Ireland Executive and the Northern Ireland Assembly.

The economic and social background

53 Whilst it is not for this Inquiry to engage in an extensive historical review of social and economical conditions in Northern Ireland during the 73 years covered by our Terms of Reference, those conditions cannot be ignored when considering the resources available to residential institutions, public authorities and government in the field of residential childcare. The statistics to which we refer are merely some indicators of what was generally a very challenging economic and social background against which the activities of the residential institutions, public authorities and the Government have to be viewed.

54 For many years the financial circumstances and living conditions of a substantial section of the population of Northern Ireland were extremely poor. For example, between 1923 and 1926 the unemployment rate remained between 20% and 23%.[1] Despite a number of public work schemes that were provided in an attempt to reduce unemployment, in the early 1930s unemployment in Belfast reached almost 30%.[2] Whilst unemployment rates were lower after the Second World War, in 1946 the average percentage of male unemployed was 10.7%, although this declined to 7.6% in 1948.[3] In the 1950s and 1960s unemployment remained stubbornly high, particularly male unemployment. Thus as late as 1958, the average yearly percentage of male unemployment was 10.1%, whilst that for females was 7.8%, giving an average yearly percentage of 9.3%.[4]

55 The decline of employment in traditional industries such as linen and ship building was to some degree offset by an influx of large employers in the synthetic fibre industries during the 1950s and 1960s. In the post-war period the Northern Ireland Government made considerable efforts to attract new industries to Northern Ireland in an effort to reduce unemployment and improve overall prosperity. The Industries Development Act (Northern Ireland) 1945 enabled an estimated additional 31,000 jobs to be created by the provision of two million square feet of government-owned factory

1 Moreau, Piere-Vincent, 'Poverty Relief and the Economic Crisis in the Region of Belfast from 1921 – 1939 (The Workhouse – workhouses.org) http://www.workhouses.org.uk/Belfast/moreau2.pdf p.5.
2 Piere-Vincent Moreau, 'Poverty Relief and the Economic Crisis in the Region of Belfast from 1921 – 1939 (The Workhouse – workhouses.org) http://www.workhouses.org.uk/Belfast/moreau2.pdf p.6.
3 *Ulster Year Book* 1950 (Belfast: HMSO, 1950) p.194.
4 *Ulster Year Book* 1957 – 1959 (Belfast: HMSO, 1959).

space. This enabled 200 firms to be assisted. One commentator has suggested that:

> "The promotion of government-funded advanced factories rather than social housing was to get preferential treatment in the post-war reconstruction of the 1940s and 1950s. ...On the negative side, the [1945 Act] hindered raising the quality of the Province's housing stock because resources used in building these factories could have been invested in housing".[5]

56 Although the Northern Ireland Government's drive for new industries created almost 72,000 new manufacturing jobs after 1945 – over 44% of total employment in manufacturing industry[6] – the rising oil prices and excess capacity in synthetic fibre production in Europe, and increased competition from low-wage developing countries, had a very severe effect on Northern Ireland industry by the 1980s.

57 Housing conditions for many remained extremely poor, particularly in Belfast. The German bombing raids of Belfast in April and May 1941 resulted in the destruction of 3,200 houses, and a further 53,000 were damaged. A sample of rural life in five areas of Northern Ireland involving 1018 houses carried out in 1944 revealed that just 8% of the houses had mains water supply, and only 6% had mains sewerage or satisfactory private water-borne disposal. Some areas, particularly in the west of the province, were found to be very much worse than average. It was estimated in 1947 that "96% of all houses in County Fermanagh have no running water."[7]

58 Whilst the 1960s and early 1970s were marked by major slum clearance and redevelopment schemes, particularly in Belfast, the 1974 *House Condition Survey* showed that less than half of Belfast's 123,000 homes were sound, around 30,000 were unfit, and a further 32,000 were in need of improvement or major repair. Over 40,000 of the total housing stock lacked one or more of the five basic amenities of a water closet, fixed bath or shower, wash-hand basin, kitchen sink, hot and cold water.[8]

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5 Brownlow, Graham, 'The causes and consequences of rent-seeking in Northern Ireland, 1945-72, Economic History Review 60:1 (2007) p.77.

6 *Ulster Year Book* 1975 (Belfast: HMSO, 1975) p.110.

7 Melaugh, Majority Minority Review 3: Housing and Religion in Northern Ireland (Centre for the Study of Conflict, University of Ulster, 1994) http://cain.ulst.ac.uk/issues/housing/docs/mm31.htm (webpage, no page reference).

8 *Ulster Year Book* 1980 (Belfast: HMSO, 1980) p. 115.

Part Three

59 In this Part we set out observations on residential childcare practice in relation to our findings, largely grouped under the headings of the main types of alleged abuse.

Changes in residential childcare

60 It is important to first acknowledge that there were very significant changes in residential childcare during the seven decades covered by the Inquiry's Terms of Reference, which stretched from 1922 to 1995. The oldest witness who gave evidence to the Inquiry was in a children's home in the late 1920s, almost ninety years ago. Compared with care provided at that time, the conditions in which children were accommodated had improved greatly by the 1990s. For example, physical standards of care were much better, staffing levels were increased and staff training was improved. Children were cared for in smaller groups and there was an emphasis on siblings being cared for together. Children received greater individual attention with the introduction of key workers, and field social workers visited children in homes more regularly. Formal reviews were introduced and increasingly children and their families were involved in care planning.

61 The reasons for children being in care also changed over the decades. In the early decades of our remit many children were placed in care on a private basis because they were illegitimate or their parents were unable to provide for them. These children tended to stay all of their childhood and early youth in residential care. By the 1970s and 1980s more preventive measures and greater practical support to help maintain children within families and less stigma about illegitimacy meant that fewer younger children were admitted to care. Where it was considered necessary to accommodate young children outside their families, fostering was seen as the most appropriate form of care. Older children continued to be admitted to residential care although in smaller numbers and mainly because they were deemed to be beyond the care and control of their parents and in some cases were getting involved in petty crime and/or anti-social behaviour associated with the Troubles. These young people tended to stay in care for shorter periods and the focus was on returning them to their families.

62 We are also aware that further improvements have been introduced in the twenty-one years since 1995, and in particular, social workers and residential childcare workers are now registered and regulated by the Northern Ireland Social Care Council and they and their employers are required to adhere to Codes of Practice.

Sexual abuse

63 The sexual abuse of children and young people by staff was one of the two main areas of complaint we received. There were some instances in which female staff were alleged to have sexually abused either boys or girls. However, by far the majority of the alleged abuse was by male staff, and because of the historical patterns of staffing, the predominant type of abuse alleged was of male staff abusing boys. The alleged abuse ranged from inappropriate touching and fondling of boys who were fully dressed to anal rape. While there was some evidence about grooming behaviour, in many cases intimidation and physical abuse occurred in tandem with the sexual abuse.

64 In some of the homes we investigated there were multiple sexual abusers. We are aware that this phenomenon has also occurred in children's homes and boarding schools in other countries. In one case there were two abusers who knew each other prior to taking up post; in another case all the care and teaching staff were of the same gender as the children; in another instance the head of the home was an open abuser, which will have reduced any chance for the children to report abuse and may have encouraged other staff who were inclined to also abuse. But none of these factors was apparent in every instance or sufficient to explain the numbers of abusers in these homes. We consider that this is an area that would benefit from further research.

65 We found that from the mid-1980s there were significant improvements in the awareness of managers and staff of the risk of sexual abuse in residential care, complaints processes for children and investigation of complaints and use of disciplinary procedures. However, we still found examples of a lack of rigour in selection procedures, a lack of regular supervision of staff, poor use of disciplinary processes including examples of staff who were suspected of sexual or physical abuse of children being moved to a different establishment or allowed to leave their post without the completion of proper disciplinary processes. Therefore, we would emphasise that rigorous recruitment practice and regular supervision of staff are essential elements in keeping children safe in residential care.

66 We heard many allegations of sexual abuse by peers. These related mainly to boys, though there were some instances concerning girls. Strictly speaking, it may be inaccurate to term the abusers 'peers', as they were mostly a few years older than their victims. Many of the witnesses who faced allegations of the sexual abuse of their juniors told us they had been abused by older boys when they were younger. It was also the case that some of this learnt behaviour manifested itself as part of wider bullying by older boys. Some appeared to have genuinely forgotten they initiated any such behaviour but it was clear it was still a source of painful memories to the victims. The complaints about peer sexual abuse mainly dated back to times when children were being accommodated in large dormitories in over-crowded and poorly staffed children's homes.

67 Where sexual activity occurred between those of approximately the same age it generally did not lead to complaints, as it was seen by the participants as normal and not a source of concern, and it could sometimes be attributed to adolescent exploration.

Physical abuse

68 Physical abuse by staff was the other main sources of complaint. In the early decades of our remit the use of corporal punishment was generally accepted within families and schools and the statutory regulations governing the provision of residential childcare included directions about how corporal punishment should be administered and recorded. However, there were periods in certain homes when a culture of informal physical punishments was pervasive. Witnesses clearly distinguished between the administration of formal and informal physical punishment as a direct consequence of their misbehaviour and the random application of excessive physical abuse which they experienced as staff exercising power and control over them. We heard evidence of some staff who clearly lost their temper and applied uncontrolled physical punishment. In some institutions staff were said to have used a variety of implements to beat children, including canes, belts, sticks, slippers and other items which came to hand such as curtain rods.

69 The actions of these staff were not only counter to the statutory regulations about administration of corporal punishment but also counter to their organisations' policies about the discipline of children. The impact of the culture of informal punishments, especially when underlined by more serious violence on the part of staff, was significant. Many witnesses told

us they were terrified, not knowing when they might be the subject of punishment. It was clear that for many witnesses the experience of seeing excessive physical force used against other children coupled with the fear of being subject to random violence was almost as, and in some cases more, damaging than the actual physical chastisement they received.

70 This was an area of abuse where individual staff members were influential; a small number were identified as being seriously abusive, but there were others who, while they were more benign, took no action to report or limit the behaviour of their colleagues. While physical chastisement of children is no longer acceptable and has no place in residential care the exercise of authority by staff still needs to be carefully supervised and monitored, and workers need support and training to deal safely and effectively with the volatile and at times aggressive situations that can be a feature of residential childcare. In addition, workers need to take individual responsibility for managing their behaviour and addressing and/or reporting any inappropriate behaviour by colleagues. While senior staff have a particular responsibility for being alert to abuse, it is also the responsibility of the whole staff team and other professionals who relate to homes such as field social workers. It may well be a junior member of care staff or an ancillary worker whom a child feels comfortable approaching and telling about abuse. Each person who may be approached in this way therefore has the responsibility for listening and reporting onwards as appropriate and persisting until satisfied that the message has been heard and acted upon.

71 The values and attitudes of every member of staff are important, but those of the head of the home are particularly significant in setting the tone and expectations for both staff and children. From the evidence we heard there were excellent heads of home who introduced new and enlightened practices and witnesses talked of how their influence greatly improved the quality of their lives. Sadly, there were those who abused children and whose conduct left the children with no one in authority to whom they could complain.

72 As with sexual abuse by peers, the majority of the allegations concerning physical abuse by peers were about young boys being bullied and physically abused by older boys who had been left in charge of them. Some witnesses talked about the maintenance of status in “pecking orders” and expressed the view that some degree of bullying was to be expected. However, others described being physically intimidated and beaten by other boys

on a continual basis and indicated that at times this abuse occurred with the knowledge and implied approval of staff. It was significant that when the homes in question were remodelled and modernised, with smaller bedrooms and better staffing, the complaints we received about peer physical abuse and bullying reduced dramatically.

73 Some institutions faced major problems of absconding, and secure rooms or suites were used to ensure that unsettled children did not absent themselves and were also used to provide time-out for children who were misbehaving. Such a solution should only be temporary; however, from the evidence we heard it was clear that in some institutions there was overuse of this provision. It was also the case that in some homes without secure rooms children were shut in confined spaces such as brush cupboards or drying rooms. This was strictly against the Regulations.

74 A major source of complaints in two homes during the later years of our remit concerned restraint. We recognised that there were times when children and young people had to be restrained, because of the risk of them harming themselves or others, or doing serious damage. However it was clear that not all staff received appropriate training in the use of alternative techniques such as diversion or talking through situations which meant that in some homes restraint was used too often. Also, where staff were not properly trained in safe methods of restraint some witnesses were left feeling frightened and physically abused rather than safely contained.

75 In one institution we found evidence that drugs had sometimes been administered primarily to control children. While it is not for us to comment on medical matters, the use of drugs in this way for social care purposes is clearly unacceptable.

Emotional abuse

76 It was clear from the evidence that there was a strong link between emotional abuse and sexual and physical abuse. Indeed, often it appears to have been the anguish caused by the sexual and physical abuse which made the sexual and physical abuse memorable. We found, though, that there were also other practices which were emotionally abusive.

77 Some staff appear to have used various ways of humiliating children, such as:

- name-calling, perhaps picking on the unattractive features of a child;
- denigrating the parents or family of a child;
- suggesting a child had inherited the negative qualities of a parent and would never be of value; or
- showing a child up in front of the group, in relation to a personal matter, which the child would have wanted to be treated confidentially such as bedwetting, deafness or menstruation.

78 This type of abuse was mainly a feature of large children's homes run by Roman Catholic congregations and appeared at some level to be prompted by a wish to ensure that children did not repeat what was seen as the "sins" of their parents and also a concern that children should not "get above themselves". Clearly such behaviour was unacceptable and had a profound impact on witnesses. Many told us of how the subsequent low self-confidence and poor self-esteem have adversely affected their ability to establish and maintain successful adult relationships and parent their children. Again, we found that complaints about these forms of cruelty diminished when staffing levels increased and staff training was improved.

Neglect

79 The most serious complaints about food, clothing, bathing conditions and other aspects of physical neglect appear largely to date back to the 1940s and 1950s, at a time when there were also poor conditions in some family homes and widespread poverty in the community at large. Standards were undoubtedly well below the acceptable in some homes. Witnesses described poor food, inadequate toilet facilities and lack of heating in the large homes which were not designed to accommodate large numbers of children. In the later decades, physical standards in homes improved greatly with the assistance of government funding and there were instances where the resources and facilities available to children were beyond those they would have enjoyed in their family homes and local schools.

Unacceptable practices

80 Some of the unacceptable practices reported to us by witnesses included the confiscation of personal possessions, force-feeding, excessive chores, queuing for bathing, the use of Jeyes fluid, and the systems used for the

management of enuresis. These practices were particularly prevalent in the 1950s and 1960s in homes where very few staff were managing large numbers of children. None of these practices would now be considered acceptable.

Underlying Issues

Governance and Finance

81 We came across a range of issues which were not systemically abusive of children or young people but were systemic failures, sometimes with consequences for the resident group. As we explain in detail in Chapter 2 we found significant weaknesses in governance arrangements including a lack of clarity about the role of management committees and a failure of some committees to monitor the quality of the conditions children were living in and the direct care they were receiving. There were also examples of management committees not being informed about complaints concerning serious sexual and physical abuse of children by staff.

82 As with other aspects of residential childcare, governance arrangements improved over the decades and by the 1980s monitoring arrangements were in place, were regularly adhered to and properly recorded and reported. However, we found in some instances that although a significant amount of resources were invested in monitoring and resulted in senior managers and Committee members achieving a good understanding of the challenges facing particular homes they proved less effective in addressing the resource and strategic management issues that were contributing to the challenges.

83 In relation to lack of resources we found this affected not only the quality of physical care which homes could offer but more importantly the level of staffing. Low staffing levels were a feature of large voluntary homes, which often were dependent on members of religious communities working very long hours looking after large numbers of children. This led to older children resident in the home and previous residents returning to visit the home being put in charge of younger children and this provided conditions which enabled the physical and sexual abuse of younger children.

Sizes of homes

84 Approximately four out of every five applicants to the Inquiry were in one of the large children's homes, mainly in the 1950s to 1970s. We have referred above to how unacceptable practices, particularly in relation to

bathing and excessive chores, were a feature of such homes. It was also clear that many of the children and young people in these home did not get the individual attention they needed, which led to some misbehaving to gain attention and others feeling uncared for and lacking in self confidence.

85 We were interested to note that as early as 1950 the Home Office issued guidance on good quality residential childcare which advocated smaller homes and included an appendix on ways in which larger homes could be broken down internally into smaller family-sized groups. However, it was the case that mainly because of lack of resources, though also because of lack of agreement about what form revised accommodation should take, it took until the late 1960s/early 1970s before such changes were introduced in the larger voluntary children's homes in Northern Ireland.

Sound standard residential childcare

86 We received evidence from many witnesses which indicated that, in the earlier decades in particular, the professional standards of care were poor. Some homes kept virtually no records of children's progress. In the case of children privately placed in homes there was little assessment of children's needs and no move to see whether reintegration into their families was possible. In the earlier decades, even when welfare authorities were involved in placing a child in a home, there was often very limited follow-up contact maintained with the children. Consequently, there were no individual care plans, no monitoring of the progress of the children or consideration of their future needs. A number of witnesses described being discharged from children's homes at short notice and being unprepared for life after care and receiving minimal ongoing support. While people who had left homes were often welcomed back for a meal or visit there was no systematic follow-up. This was particularly marked in the case of children who had been sent to Australia who for all intents and purposes appeared to have been forgotten.

87 Over time, standards improved and sound professional practices were introduced. There was evidence from the 1970s onwards of: assessment of children's needs; the planning of care programmes; the maintenance of family contact where possible; the availability of systems of advocacy and for making complaints; and, aftercare on returning home or living independently. Many witnesses told us they felt they had no-one to turn to about the abuse they were suffering and some told us they did report the abuse but were not listened to or believed. The evidence we received

suggested that this improved so that by the 1980s and 1990s children's allegations and complaints received proper attention. There is no doubt that greater awareness of the risk of physical and sexual abuse in residential children's homes, particularly in the aftermath of the identification of abuse in Kincora and Rubane, meant that greater emphasis was placed on external monitoring of children's homes and having proper procedures for children and their families to raise concerns and make complaints.

88 In this section we have summarised the types of abuse we have heard about and indicated how standards and conditions improved over time. Although we found evidence of systemic failings in every decade of our remit it was the case that in some homes improved staffing levels, better qualified staff, smaller group living and more external governance of homes led to enormous improvements in the care children received. It is also important to acknowledge that throughout the decades some staff provided good care and warmth to children and were genuinely concerned to help them grow and develop and often worked unstintingly with little support to do so. We are of the view some staff abused children both physically and sexually, and even took pleasure in doing so. However, we recognise that there were other staff who responded inappropriately under the extreme pressure of caring for too many children with little training and support and in poorly designed and inadequate conditions.

Part Four

The format of the Inquiry and the Report

89 The Inquiry divided the institutions and issues investigated into fifteen modules, and, as appropriate, one or more issue or institution was examined in each module. Institutions, organisations and individuals being investigated in a particular module were provided with the documentary evidence gathered by the Inquiry which we felt was relevant to the issue(s) to which the person or organisation could be expected to speak and assist the Inquiry. Individuals, bodies and institutions were asked to deal with relevant issues identified by the Inquiry in their witness statements, and at the end of each module were given the opportunity to make written and oral submissions in respect of matters raised by the Inquiry, or alleged by individuals or other organisations. Most individuals, institutions and other bodies made submissions at this stage, and some took the opportunity to admit systemic failings and express regret for those failings.

90 The panel then prepared a draft chapter or chapters dealing with the institution or issues considered in each module. After the public hearings each institution or individual who was subject to a criticism in the draft Report was sent a Warning Letter and invited to respond by a certain date, the time allowed for responses being calculated to allow for the nature of the criticism and the length of the part of the Report provided to them. In those cases where an individual was criticised but had not been asked to give evidence to the Inquiry, or in some cases had been offered the opportunity to give evidence but had declined to engage with the Inquiry, the individual was offered legal representation at the expense of the Inquiry (if their means required this) and the opportunity to make submissions.

91 The responses were then considered by the Inquiry panel and the draft amended if necessary as we considered appropriate having taken the submissions into account.

92 The Report consists of twenty-nine chapters comprising nine volumes. The tenth volume consists of the Report of the Acknowledgement Forum.

The cost of the Inquiry

93 There will be expenditure by the Inquiry after the delivery of the Inquiry Report, and its publication, associated with winding up the Inquiry and placing the Inquiry Record with the Public Record Office of Northern Ireland. Including these costs the estimated cost of the Inquiry is £13,250,000, of which an estimated £575,000 will be borne by the Northern Ireland Office because it represents the additional cost to the Inquiry of investigating the non-devolved departments and agencies in the context of Kincora. This means that the net cost of the Inquiry to the Northern Ireland Executive is estimated to be in the region of £12,675,000. This represents the costs incurred by the Inquiry, and does not include the costs of Northern Ireland Executive departments or other agencies, which were not the responsibility of the Inquiry.

Appendix 1

Definitions of abuse and systemic failings

The Terms of Reference of the Inquiry required it to consider whether "there were systemic failings by institutions or the state in their duties towards those children in their care", children in this context being children in residential institutions (other than schools). This required the Inquiry to address three questions. (a) What were the duties of the institutions and the state towards the children? (b) What constituted "abuse"? (c) What amounted to "systemic failings"?

The Inquiry applied the following broad definitions when considering the evidence it gathered. These were intended to be broad, general definitions because the Inquiry did not seek to exhaustively define in advance everything that might amount to "abuse" or "systemic failings", and therefore when the Inquiry came to consider specific circumstances it was sometimes necessary to amplify these definitions in the context of those circumstances.

1. The duty of an institution was to provide an environment in which the children in their care would (a) receive proper physical care in the form of food, clothing, accommodation and medical attention; (b) be free from emotional, physical, or sexual abuse, or from neglect; and (c) develop through the provision of childcare in accordance with standards acceptable at the time

2. The state had the same duty towards children as a voluntary or religious institution where the state directly provided residential institutional care, either by central government in the form of places of detention, hospitals or residential schools for children with special needs or by local government, and later by public bodies such as health and social service boards or health and social care trusts.

3. The state also had a separate duty to ensure that all institutions maintained proper standards of care of the children in the institutions because (a) it was obliged by law to regulate and inspect the institutions, or (b) it funded either all or part of the capital and/or running costs of the institutions.

4. "Abuse" was behaviour which either (a) involved improper sexual or physical behaviour by an adult or another child towards a child; or (b) in the case of emotional abuse, was improper behaviour by an adult or another child which undermined a child's self-esteem and emotional well-being, such as bullying, belittling or humiliating a child; or (c) resulted in

neglect of the child; or (d) took the form of adopting or accepting policies and practices, such as numbering children or ignoring or undermining sibling relationships, which ignored the interests of the children.

5. A "systemic failing" by an institution consisted of either (a) a failure to ensure that the institution provided proper care; or (b) a failure to ensure that the children would be free from abuse; or (c) a failure to take all proper steps to prevent, detect and disclose abuse, or (d) take appropriate steps to ensure the investigation and prosecution of criminal offences involving abuse.

6. A "systemic failing" by the state consisted of a failure to ensure either (a) that the institution provided proper care; or (b) that the children in that institution would be free from abuse; or (c) a failure to take all proper steps to prevent, detect and disclose abuse in that institution, or (d) take appropriate steps to investigate and prosecute criminal offences involving abuse.

7. "Systemic failings" could also have taken place in one or more of the following ways:

   (a) where some or all of those who had contact with children in residential establishments, including volunteers and visitors, adopted abusive childcare practices in common;

   (b) where staff in managerial positions within residential establishments initiated, encouraged or condoned abusive childcare practices;

   (c) where people in positions of responsibility for the institutions running residential services initiated, encouraged or condoned abusive childcare practices;

   (d) where those responsible for the inspection, oversight, policy-making or funding of the institutions providing residential services initiated, encouraged or condoned abusive practices, or failed to take appropriate steps to identify, prevent or remedy abuse."

Chapter 2:

Governance and Finance

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Part One: Governance

Introduction

1 During the period 1922 to 1995, two levels of governance operated for voluntary and statutory children's homes and criminal justice institutions for young people: inspection by Government departments and internal monitoring by providers of the residential care. Powers, duties and requirements in relation to inspection and monitoring of children's homes were set down in legislation, statutory regulations, Government circulars and related policies and procedures of care providers. Also, in addition to these formal arrangements, welfare authorities had to assure themselves of the care provided to children they placed in voluntary homes as they still remained responsible for them in law.

2 In this chapter we will outline how requirements in relation to inspection and monitoring of children's homes and institutions developed during the period 1922 to 1995 and will consider at a general level to what extent they were implemented and proved effective. In each of the chapters dealing with individual homes and institutions, we have considered how effective inspection and monitoring activity was in identifying and addressing issues about the adequacy of the physical conditions and facilities in homes and the quality of the care provided to children and young people living in them.

The period 1922 to 1950

3 In 1922 the residential care of children was governed by the Children Act 1908 and by the Poor Relief Acts, which empowered Boards of Guardians to care for children in workhouses or to have them boarded out. The limited provision for governance of residential care of children was contained in the Children Act 1908, which provided for certified reformatories and industrial schools to be inspected at least once a year and gave the Secretary of State the power, but not the duty, to inspect children's homes. Section 25 of that Act stated:

> "the Secretary of State may cause any institution for the reception of poor children or young persons, supported wholly or partly by voluntary contributions and not liable to be inspected by or under the authority of any other government department, to be visited and inspected from time to time be persons appointed by him for the purpose."[1]

1 HIA 100-101.

The Secretary of State had no power under this legislation to require voluntary homes to be registered nor could any government department intervene in the arrangement for the training, education or after-care of children accommodated within them.[2]

4 The Ministries of Northern Ireland Act (1921) established the Northern Ireland Ministry of Home Affairs (MoHA) and made it responsible for the inspection powers and duties set down in the 1908 Children Act. In compliance with legislation and guidance the majority of departmental files and records relevant to the time period covered by this Inquiry have been reviewed and either destroyed in accordance with records management procedures or passed to the Public Records Office of Northern Ireland (PRONI). Only a few records of inspection activity still exist, therefore the Department of Health, Social Services and Public Safety (DHSSPS) was unable to confirm to what extent inspection of children's homes was carried out between 1922 and 1995. MoHA inspection reports were confidential to the Ministry and not shared with children's homes so copies of them were not available in the records maintained by homes. However, the homes' records did contain some related material such as letters from the MoHA following up matters identified during inspections and later inspection reports by the Social Work Advisory Group which were shared with homes, all of which assisted our considerations.

5 The limited number of inspection reports that were available to us for this period showed that inspections were generally undertaken on an annual basis by a MoHA children's inspector and a medical officer. The reports of the inspections tended to focus on the physical environment and facilities available in homes and contained only brief comments about the appearance and general health of the children. We saw evidence in records maintained by providers of care, for example the Sisters of St Louis, that the MoHA wrote to homes to follow up issues identified during inspections and that this extended to seeking information about the medical care being provided to particular children.

6 The MoHA was also responsible for inspecting reformatory and industrial schools, and reported annually on these institutions within a report to the Governor of Northern Ireland about services and functions in regard to law and order. The information provided in these reports included the number of children each establishment was certified to hold, the grounds for

2 HIA 1095.

committal, statistics in relation to admissions and discharges, and funding arrangements. For example, it was reported that in 1927 forty-five boys and eighteen girls were admitted to industrial schools, and the grounds for committal were non-compliance with School Attendance Orders in twenty-six cases, begging in eleven cases, wandering in nine cases, minor offences in nine cases, and destitution/being orphans in eight cases.[3]

7 Information was also provided about the health of the children and the medical attention they received, the education and training provided to them and, in the majority of cases, the employment they entered on discharge. In the report for 1927 it was recorded:

> "At the annual inspections of the various Schools during the year the children in general looked healthy and cheerful and bore every appearance of being well cared for; the dietary on the whole was adequate; and the general condition of the Institutions was excellent."[4]

The 1934 report moved from a confirmation that all institutions had been inspected and a summary of general comments to the provision of brief quotes from the inspection reports of each school. For example, it was reported that all the boys in St Patrick's reformatory and industrial school looked well cared for and the school was "bright and cheerful as the result of internal re-decoration carried out in a very creditable manner by the inmates."[5]

8 The next piece of relevant legislation was the 1946 Public Health and Local Government (Administrative Provisions) Act (Northern Ireland), which established welfare authorities to carry out the functions of the Boards of Guardians. Eight welfare authorities were established across county and county borough council areas in Northern Ireland. Each welfare authority was required to appoint a Welfare Officer who would assume the responsibilities that had previously been invested in the Boards of Guardians. The welfare authorities were also required to act through statutory welfare committees. This structure divested the Boards of Guardians of their responsibility for children.

9 In 1946 the Government also published a White Paper *The Protection and Welfare of the Young and the Treatment of the Young Offender* and the recommendations contained within it were given legislative force

3 GOV 35028.
4 GOV 35028.
5 GOV 35071.

through the Children and Young Persons Act (Northern Ireland) 1950 (referred to below as the CYP Act 1950). The CYP Act 1950 centralised the Government's responsibility for the care of children under MoHA and gave the MoHA more powers and duties in relation to the inspection of children's homes.

The period 1950 to 1972

10 At the time of the passage of the CYP Act 1950 the majority of children in residential care were accommodated in voluntary homes run by Roman Catholic religious orders and had been placed in the homes mainly on a private basis. In an attempt to improve the regulation of these homes the CYP Act 1950 provided that:

a. voluntary children's homes had to be registered by the MoHA.[6]

b. a voluntary children's home's registration could be removed if it appeared to the MOHA that it was being conducted in a manner that was not in accordance with regulations made or direction given under the Act.[7]

c. any person appointed by the MoHA to inspect a voluntary home had the power to enter such homes and to make "examinations into the state and management thereof and the conditions and treatment of children therein as he thinks requisite."[8]

11 The MoHA's initial focus in implementing the CYP Act 1950 was the registration of existing voluntary children's homes. From 1950, the report to the Governor of Northern Ireland was extended to cover child welfare services and included information on the progress the MoHA was making in meeting its new responsibilities for registering and inspecting voluntary children's homes. The report of 31 December 1950 recorded that seventeen voluntary homes had been registered,[9] and by the time of the report issued on 31 Dec 1954 this number had increased to twenty-three registered homes.[10]

12 Documentation relating to the initial registration of Manor House, a voluntary children's home in Lisburn run by the Irish Church Missions, gave us an insight into the registration process. A MoHA children's inspector, Ms

6 Section 99(1) HIA 232.
7 Section 99(4) HIA 233.
8 Section 102 HIA 237.
9 GOV 35038.
10 GOV 35051.

Forrest, visited the home on 8 June 1950 and met with a member of the Management Committee of the home and the matron and inspected the facilities. Miss Forrest provided a brief report on her general impressions of the home for her senior colleagues. On 22 June 1950, the Management Committee submitted an application for the home to be registered, which included information about how many children could be accommodated in the home, the current number of children accommodated and the number of staff caring for them. Seven days later, in a letter dated 29 June 1950, the MoHA wrote to confirm Manor House had been granted registration and that the Ministry would consider applications for funding to assist the improvement of premises or equipment and the securing of qualified staff.

13 This letter also explained that the MoHA intended to issue regulations for the conduct of children's homes, but that its powers to inspect children's homes would be put in force straight away and that inspectors would carry out their first inspections within the next few weeks.[11] However, despite this indication that an inspection was imminent no inspection took place and almost three years passed before a MoHA official visited the home.

14 The short period of time the MoHA took to consider the application suggested that the decision to register the home was based on Miss Forrest's initial assessment of it, with the expectation that a closer look at its operation would be achieved through inspection. In relation to the lack of inspection of Manor House in this post-registration period the Department of Health, Social Services and Public Safety (DHSSPS) as the successor body to the MoHA, pointed out that the MoHA would have been under pressure at that time coping with the requirements of the new legislation, including the registration of all voluntary homes.[12]

15 We accepted this and recognised that at this time there were only two children's inspectors to cover the whole of the province. We also noted from MoHA files and records maintained by providers of care that in addition to dealing with registration of voluntary homes the inspectors provided feedback on funding applications and advised on the development of services. However, as we set out in our findings in Chapter 20 which deals with Manor House, the lack of inspection at this time was significant because conditions for the children in that home deteriorated considerably in the period between registration being granted and the first inspection.

11 MNH 2927.
12 MNH 306.

We found that lack of resources for inspection of children's homes by Government departments was a recurring issue, which we will return to later in this chapter.

16 The MoHA issued Statutory Regulations to support the implementation of the CYP Act 1950 - the Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland) in 1952.[13] These Statutory Regulations specified arrangements that providers of residential care for children were required to put in place for the monitoring of their homes. A copy of these Regulations can be found at Appendix 1 to this chapter.

17 In the 1950s inspection reports continued to be confidential to the MoHA and again the Government's records management and disposal policy meant that only a few inspection reports from that period were available to us. The reports we saw continued to be brief and focussed mainly on the numbers of children being accommodated, the number of staff available to care for them, the physical condition of the home and the status of any funding application for improvements to the home. They did include confirmation that inspectors had examined records that homes were required to keep, such as those about the administration of corporal punishment. In the main, the comments relating to the direct care of the children were limited and somewhat superficial even in reports that contained critical comments about poor physical conditions in homes, including overcrowded bedrooms and inadequate toilet and bathroom facilities, poorly clothed children and low staffing levels.

18 Miss Forrest, recorded her concerns about the conditions in some voluntary children's homes in a memorandum she sent to senior colleagues in April 1953, in which she provided her brief impressions of all the voluntary children's homes. A copy of Miss Forrest's memorandum can be found at Appendix 2 to this chapter. In relation to the two children's homes in Londonderry and the two homes in Belfast run by the Sisters of Nazareth she reported poor conditions and inadequate staffing and, for example, described Nazareth Lodge in Belfast as "very institutional for older children, and babies in desperate plight."[14] She summarised her views about these four homes:

> "I find these Homes utterly depressing and it appals me to think that these hundreds of children are being reared in bleak lovelessness."[15]

13 HIA 288.
14 HIA 1463.
15 HIA 1464.

19 Despite Miss Forrest's recommendation that the MoHA should press for a complete overhaul of these homes and assist in every way possible, the poor conditions in these and other voluntary homes, such as Rubane which was run by the De La Salle order in Kircubbin, were allowed to persist and in some cases worsen for a considerable number of years. When Miss Forrest visited the home Nazareth Lodge on 9 January 1954 she found little improvement in the conditions and recorded that while she found the babies "well-cared, well-clothed and fed"...

> "The whole premises - except the parts immediately above the laundry and boiler-house - were dreadfully cold. ...The babies' hands were blue with cold and felt icy to touch. ...The school-children are now the worst off and Rev. Mother agrees that they are not getting any sort of chance in life and cannot make proper development, especially those who have known nothing but this institutional care from babyhood. ...What is needed here is really fundamental re-organisation so that these little creatures can have some individual loving care instead of being dragooned. Rev. Mother recognises this and even went so far as to say that children playing in the gutters of the slums were better off, if they had a father and mother to care for them, however poorly".[16]

20 In the inspection reports we had access to, inspectors repeatedly recorded that they had made clear to providers that improvements were needed to the physical conditions in homes, but there was little evidence of the MoHA using its statutory powers, including the ultimate power of removing registration from a voluntary children's home, to require improvements. We are aware of only two occasions when the MoHA actively considered removing registration from a children's home. The first occasion was in 1953 when inspectors found dire physical conditions in Manor House. The Irish Church Mission (ICM) which ran the home agreed to remove the children and close the home. However, due to the intervention of the then Minister of Home Affairs, who advised a sympathetic approach, the ICM was allowed to retain registration of the home while first deliberating on its future and then planning for it to reopen. The second occasion was when the Good Shepherd's home in Newry was failing to comply with fire regulations. Following letters from the Secretary of the MoHA to the Mother Superior and to the solicitors acting for the home the necessary work was completed and the fire certificate issued. Both these examples showed that an assertive approach by the MoHA achieved results.

16 SNB 16116.

21 The MoHA was not just dependent on inspection activity to ascertain the standards in children's homes. The Child Welfare Council (CWC) was established under Section 128 of the CYP Act 1950 and was charged with the duty of providing advice to the MoHA about how it was performing in relation to its functions under the 1950 Act, and to make representations to the MoHA with respect to any matter affecting the welfare of children and young persons. As part of meeting this remit, the CWC visited children's homes and reported its findings. In 1955 a Study Group established by the CWC visited eighteen of the, by then, twenty-four voluntary children's homes registered by the MoHA, and almost all of the fourteen children's homes provided by welfare authorities. The CWC reported the findings of the Study Group in its 1956 report *Children in Care*, which included the observation that a number of children's homes visited, both statutory and voluntary

> "seemed to be seriously understaffed especially for the care of babies and we feel that this problem affects most children's homes from time to time because of the periodic fluctuations in the number and type of children who have to be cared for."[17]

22 The CWC recognised that it was difficult to set down an exact ratio of staff to children given the range of homes and the range of ages of children cared for in them. However, it proposed that excluding cooks and domestic help, the ratio of full-time staff for children under five should not be less than one to three, and where the children were older, this ratio might be reduced as far as one in six. We noted that in the MoHA's 1956 report to the Governor of Northern Ireland, which was by then entitled *Report on the Administration of Home Office Services*, reference is made to the publication of the CWC's report *Children in Care*. It received wide publicity, but no indication was given of the MoHA's view of the findings in the report or of any action it proposed to take to address the concerns expressed within it about conditions in children's homes in the province.[18]

23 Miss Forrest accompanied members of the CWC Study Group on their visits to childrens' homes, and we saw evidence in inspection reports and internal MoHA memoranda that she referred to the proposed staffing ratios and promoted them in discussions with voluntary homes. However, there was no formal action taken by the MoHA to implement these ratios, and chronic understaffing, particularly in voluntary homes run by religious

17 HIA 1756.
18 HIA 552.

orders, was allowed to continue. In its 1966 report *Role of Voluntary Homes in the Child Care Service*, which Miss Forrest helped to draft, the CWC concluded:

> "...in many voluntary homes there are at present insufficient staff to ensure that the demands made on them are reasonable and that the children receive sufficient individual attention."[19]

24 The Department of Health and Social Services (DHSS), as the immediate successor department to the MoHA, told the Hughes Inquiry that the MoHA had issued the 1969 *Residential Task in Child Care: the Castle Priory Report*, which proposed staffing levels to welfare authorities and it was regarded by them as a guide. It also confirmed that it had issued a circular in 1974, *Planning – Manpower Guidelines* which set out staff ratio guidelines for residential establishments. The DHSSPS accepted in its evidence to this Inquiry that the recommended staffing levels for children's homes in the DHSS circular were lower than the Castle Priory guidelines but pointed out that the Eastern Health and Social Services Board had told the Hughes Inquiry that the Castle Priory standards were those it aspired to achieve.

25 The DHSSPS also referred to the DHSS's evidence to the Hughes Inquiry that administering authorities of voluntary children's homes were free to set their staffing levels and that any deficiencies in the levels set were addressed through inspections of the homes.[20] It defended the approach of its predecessor departments and stated that it remained of the view that staffing levels in childrens' homes should have been determined by the particular needs of the resident group and should have been sufficiently adequate to ensure that appropriate standards of care could be effectively promoted and maintained.[21] However, it conceded in relation to the staffing levels in the 1950s and 1960s in children's homes run by the Sisters of Nazareth in Londonderry:

> "In an era and social climate when the causes supported by charitable work and philanthropic efforts were not the responsibility of the State staff costs may have been driven down to the extent that an acceptable standard of care for children was difficult or impossible to achieve."[22]

19 HIA 552.
20 SND 15678.
21 SND 15678.
22 SND 15678/9.

We consider that this concession did not go far enough, because while charitable work may not have been the responsibility of the State it was ultimately responsible for the welfare of children in voluntary homes and recognised that responsibility through the regulatory responsibilities and powers it vested in the MoHA for the registration and inspection of these homes.

26 There appeared to be a range of reasons why the MoHA did not take more assertive action to address unsatisfactory conditions in voluntary children's homes. Some related to the availability of funding for improvements, the reluctance of some congregations to provide required information about their finances to support funding applications, and the views of politicians at that time about who should bear the cost of voluntary residential care for Roman Catholic children. We will consider these matters further in the section of this chapter dealing with the funding of residential childcare.

27 Part of the reluctance to take action, we concluded, was that the financial and logistical implications of closing a voluntary children's home would have been considerable. Large numbers of children were being cared for in these homes, which were mainly funded through public donations and depended on members of religious orders working long unsociable hours, often for little or no wages. The cost of removing these children into the care of the State would have been significant, and even if it could be afforded there would not have been sufficient places in the available statutory children's homes to accommodate them.

28 There was also evidence suggesting that the MoHA was careful to respect the rights of the Catholic Church to manage its own affairs and not to get into conflict with it about its wish to ensure that children born into its faith were raised within it. There was evidence of this in the placatory tone of correspondence from MoHA officials to Cardinal Conway in November 1965 about their concerns over the management of St Joseph's school in Middletown, and their assurance to him in subsequent correspondence that the views of the Catholic Church would be of "paramount importance" in determining the provision of training school accommodation for Catholic girls in Northern Ireland. It was also apparent in later years, when in 1993 the police informed the Northern Ireland Office (NIO), which was then responsible for training schools, that it was investigating allegations of abuse by the then principal of St Patrick's training school. Officials from the NIO and the Social Services Inspectorate (SSI) met with Bishop Farquhar in whose diocese the school was and with Father McCann, the Chair and Secretary of the Board of Management of the school, who decided that it

was not necessary to suspend the Principal while the police investigation was underway. Officials were clearly uneasy about this decision, but although they were representing the Government department responsible for the funding and regulation of the school they did not feel able to apply pressure and insist on the Principal being suspended but instead adopted a watching brief.[23]

29 It may also be the case that the MoHA's approach of not intervening directly to require improvements or not using its power to remove registration from unsatisfactory homes was due to the views of senior officials about the approach that should be taken to inspection. We noted that in internal correspondence between senior civil servants dated 31 December 1954, an "A.R." wrote to a "Mr Freer" about inspection of voluntary organisations[24] in which he commented that staff in the MoHA "have gone much too far, and made too heavy weather out of the whole business." A.R. recommended an informal approach to visiting to avoid any suggestion that the Ministry was responsible for the standards within an organisation and advised that officials should not get more deeply involved than they presently were.

30 It is probable that a combination of these factors were in play but the result, as will be seen in the chapters dealing with individual institutions, was that for many years children in some voluntary homes in Northern Ireland lived in conditions that MoHA inspectors knew were very unsatisfactory.

31 With regard to the promotion of good childcare practices within children's homes, the DHSSPS told us that the MoHA sent the 1952 Memorandum on the Conduct of Children's Homes to the secretary of every voluntary home in Northern Ireland[25] and that it promoted a model of good practice which aimed to prevent neglect and the physical and emotional ill-treatment of children in residential care. A copy of the 1952 Home Office Memorandum can be found as Appendix 3 to this chapter. The DHSSPS made the point that:

> "...the principles and good practice guidance contained in the 1952 memorandum had the potential, if implemented, to significantly diminish the potential for physical, sexual or emotional abuse and neglect of children in institutional care."[26]

23 Day 149, p.60.
24 HIA 1586/7.
25 SND 15690.
26 SND 15992.

32 We accepted this point and agreed that the Memorandum provided relevant guidance and promoted the welfare, including the emotional well-being of children in care. However, no matter how enlightened this Memorandum was, its impact was severely limited because it was not fully implemented. We heard evidence that in many homes in the province, the principles and good-practice guidelines set out in the Memorandum, for example those concerning the treatment of enuresis and the type of punishment suitable for different ages of children, were not adhered to. This lack of adherence was the responsibility of those providing the care but it was also the case that it was not picked up or addressed through inspection.

Adherence to the Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland) 1952

33 Given the limited resources available to the MoHA for inspections one would have expected it to focus on ensuring that voluntary organisations were meeting statutory regulations about the monitoring of their homes, so that it could place some reliance on internal governance identifying and addressing problems and promoting good childcare practice. However, we found that was not the case.

34 The statutory regulations placed specific duties and requirements on the "Administering Authority" of homes, which was defined in Regulation 3(1) as the "the person or persons carrying on the voluntary home." We found that there was a lack of clarity in some homes about who was the Administering Authority. For example, in Rubane the Bishop of Down and Connor and senior priests appointed by him formed the Board of Governors, but the De La Salle order was responsible for the day-to-day management of the home. The MoHA did not seek confirmation of who was the Administering Authority, and although inspectors had regular contact with the home that contact was mainly with the brother in charge and only on a few occasions did MoHA officials engage with the Board of Governors.

35 The DHSSPS accepted in relation to Rubane in particular, but also more generally, that a fundamental purpose of inspection should be to ensure that statutory requirements were being met. It accepted that the MoHA had not clarified who was the Administering Authority for Rubane and that generally there was insufficient engagement with the Board of Governors. This lack of engagement was particularly significant, because it meant that when inspectors engaged with the De La Salle Order about alleged abuse in the home they depended on what it told them about the outcome

of investigations into such allegations without reference to the Board of Governors.

36 Regulation 4(2), of the statutory regulations was one of the most important in relation to monitoring the care and welfare of children in voluntary homes. It required that:

> "The administering authority shall make arrangements for the home to be visited at least once in every month by a person who shall satisfy himself whether the home is conducted in the interests of the well-being of the children, and shall report to the administering authority upon his visit and shall enter in the record book referred to in the Schedule hereto his name and the date of his visit."[27]

37 This regulation, which was aimed at ensuring the well-being of the children being cared for in homes, was not consistently met by voluntary agencies or enforced by the MoHA, or subsequently the DHSS. This lack of enforcement was significant as we found that internal monitoring of voluntary children's homes by management committees was mainly poor. The exceptions to this were Manor House, which when it reopened had a proactive management committee that concerned itself with the quality of care being provided to children, and Barnardo's homes, which as part of a UK organisation had detailed structures and procedures for internal monitoring of its homes.

38 We found that the management committees of homes run by Roman Catholic orders, particularly in the 1950s and 1960s, generally concerned themselves with practical and financial matters and did not specifically monitor the quality of the care the children were receiving, despite the statutory regulation requiring them to do so. This may have been partly because the efforts to secure and manage available funding had to be such a priority. However, it also appeared that respect for nuns and brothers, and an expectation that their Christian beliefs would ensure they provided good and loving care, meant that their practice was not closely monitored and their assurances about how well children were doing in their care were readily accepted.

39 There was also an expectation and acceptance that the work and conduct of nuns and brothers would be overseen by their religious orders. Senior members of relevant religious orders did make regular visitations to homes.

27 HIA 288.

However, we found that visitations focused on the religious and spiritual life of the community and did not sufficiently monitor the quality of the care being provided to children. The references to the children tended to be about their activities, accomplishments and plans, although there were some references to plans to improve the physical facilities for them. The acceptance and reliance on the internal governance of orders also led to situations where allegations of physical and/or sexual abuse of children were dealt with privately as an internal matter by orders, without reference to the relevant Management Committee/Board of Governors, or to welfare authorities responsible for the children making the allegations, or to the police.

40 We concluded that if the MoHA had confirmed the Authorising Authority for homes, made clear the regulations they were required to meet and enforced monthly visiting there would have been a greater likelihood that the legislative focus on the care and well-being of the children would have been realised. The DHSSPS conceded that it was a systemic failure of its predecessor bodies not to have ensured that the requirements of the 1952 Regulations were being met.

41 It also acknowledged with regard to Rubane that:

> "...rigour of inspection, proper monitoring by responsible authorities and clearly defined management responsibility and accountability are essential to the well being of children in care."[28]

42 We agreed with this analysis and, as will be clear from the following chapters, we were critical of where inspection and monitoring did not happen or was lacking in rigour, focus and impact. However, all the evidence we considered pointed to Miss Forrest being a conscientious and astute inspector who was concerned about children and the conditions they were living in and who worked hard to support staff in homes to make necessary improvements, and we commend her personal efforts.

Regulation of statutory homes

43 Section 89 of the CYP Act 1950 imposed a general duty on welfare authorities to exercise their powers with respect to children in care as to further their best interests and to offer them opportunities for the proper development of their character and abilities. Section 92 placed a specific

28 RUB 5964.

duty on welfare authorities to provide accommodation for children in their care "where it is not practicable or desirable for the time being to make arrangements for boarding out"[29] and set down requirements in relation to the provision of that care.[30]

44 These requirements included the provision of specific types of homes for children with different needs, the promotion of the religious upbringing of children and, in support of a policy bias towards fostering, the setting of time limits on how long children should be placed in residential care. Welfare authorities were also required to seek the approval of the MoHA for the appointment, qualification and training of staff in children's homes. Section 92 (5) of the Act provided that the MoHA could close a home if it was "unsuitable for the purposes or if the conduct of the home failed to comply with regulation."[31]

45 Following the passage of the CYP Act 1950 there was a rapid increase in the number of children received into statutory care. In 1947, 1,000 children had been placed in care by private arrangement; by 1959 this number had reduced by 249 to 751. In the same period, the number of children in statutory care more than doubled, with an increase from 501 children in 1947 to 1,148 children in 1959.[32] The policy bias for fostering was implemented in relation to these 1,148 children, with 728 of them boarded-out, 226 in statutory children's homes and 158 of them placed in voluntary children's homes by welfare authorities.

46 Section 136 of the CYP Act 1950 provided for the MoHA's powers in relation to inspection of voluntary children's homes to extend in like manner to any place other than a voluntary home in which a child was maintained under the Act, thereby giving the MoHA the power to inspect statutory children's homes and hostels.[33] The Children and Young Person (Welfare Authorities' Homes) Regulations (Northern Ireland) 1952, which were issued on foot of the legislation, set down requirements for how welfare authorities should monitor the care provided in their children's homes. Regulation 5 imposed a requirement that the Children's Officer, which each welfare authority was required to appoint, should visit each children's home at least once a month and submit a report on these visits

29 SND 164.
30 HIA 228.
31 HIA 229.
32 HIA 1096.
33 HIA 268.

to the Welfare Committee. A similar requirement extended to the Welfare Committee. Regulation 5(1) required that each children's home should be visited at least monthly by a member of the Welfare Committee who had the responsibility to satisfy himself that the home was conducted in the interest and for the well-being of the children and to report back on the visit to the Welfare Committee. Welfare authorities were also required to submit a return to the MoHA each quarter about the children accommodated in residential care.

47 Kincora and Bawnmore Boys' Home were the only statutory homes we considered which operated in this period. Taking Kincora as the example of the approach adopted it was clear from available evidence that the Belfast Welfare Authority established the necessary visiting and reporting processes to meet these monitoring requirements but did not fully implement them. In the period from 1960 to 1962, only about 50% of the required reports from the Children's Officer were minuted. However, this situation improved, and from 1968 until 1973 almost all of the required visits were completed, except for very occasional gaps during the summer holiday periods. In contrast, the Hughes Inquiry found that while the requirement for visits by members of the Welfare Committee was largely met in the years 1960 to 1965, the frequency of statutory visits declined thereafter, and that such protection as this monitoring offered residents in Kincora was largely absent in the period January 1972 to September 1973. The Hughes Inquiry accepted that not all visits may have been minuted and recognised the limitations of such visits, e.g. how willing teenage boys would be to disclose abuse to visiting committee members. However, it concluded that the Belfast Welfare Authority's record of compliance with its statutory duty to undertake visits to Kincora from 1966 to 1973 could not escape criticism and we agree with that conclusion.[34]

48 The regulations did not extend to requiring regular visits to individual children in residential care or regular reviews of their progress. The Health and Social Care Board (HSCB) accepted from the evidence provided to this Inquiry that too often, during this period, there were no records or recollections of visits made by social workers to children placed in care and that some children were only visited once or twice a year. It conceded that generally in the period before 1968 the policy and practice of field social workers making regular visits to children placed in residential care was underdeveloped in Northern Ireland by comparison with other regions

34 KIN 75223.

of the United Kingdom and accepted that was a failure on the part of its predecessor organisations.[35]

49 Robert Moore, the Children's Officer in the Belfast Welfare Authority, attempted to address this situation in 1967 by introducing a policy of a minimum monthly visit to each child placed in a home. However, the HSCB accepted from evidence provided about witnesses to the Inquiry, that this policy was not consistently applied. Also, as late as March 1985, Mr Bamford of the Southern Health and Social Services Board (SHSSB) told the Hughes Inquiry that monthly visits were not possible within the Board's existing staff resources and had to be on the basis of visiting children "as often as is necessary to provide him with meaningful support, to maintain interests in his needs as an individual and to maintain his relationship with relatives and friends and those significant to him."[36]

50 While accepting that lack of regular contact with children placed in residential care was a failure of its predecessor organisations, the HSCB suggested that part of the reason for this failure was that there was no statutory requirement for such visits and that the Government had placed different statutory safeguards on children who were boarded out as opposed to those in residential care.[37] The HSCB also pointed out that the MoHA did not provide any guidance about the maintenance of contact with children in care, although it "had overarching responsibility for policy and services to children and ultimate responsibility for children placed in residential care."[38]

51 The DHSSPS responded to this criticism and pointed out that where duties are conferred directly on a body, such as the general duty placed on welfare authorities in primary legislation to further the best interest of children or the specific duties contained within the statutory regulations, it is the responsibility of those on whom the duty is conferred to determine how best these might be discharged.[39]

52 We agreed with the HSCB that a statutory requirement would have been helpful and would have given the maintenance of contact with children placed in care the priority it deserved amongst competing demands. However, we considered that even in the absence of such a requirement,

35 GOV 656.
36 KIN 74353.
37 GOV 655.
38 GOV 654.
39 GOV 794.

welfare authorities who had taken the significant step of placing children in residential care should have recognised and met their responsibility for maintaining contact with those children.

53 There were also no statutory requirements for the review of the care and progress of children in care. Mr Moore also introduced a policy in the Belfast Welfare Authority in 1967 for such reviews to take place every three months. We saw evidence of reviews taking place in other authority areas, and of welfare committees receiving reports about the circumstances of individual children and plans for their future. However, as the HSCB accepted, an overview of the case files available to this Inquiry showed that there were inconsistencies in the convening of reviews.[40]

54 We were of the view that these inconsistencies in the level of contact maintained with children placed in care and in the review of their progress were particularly significant in relation to children placed in voluntary homes by welfare authorities, since the welfare authorities were not directly in control of the policies and practice in those homes. Regular visiting by social workers would have enabled a professional eye to be cast on the general conditions and practices in these homes.

Welfare Authorities' monitoring of standards in voluntary homes

55 The welfare authorities remained responsible in law for children they placed in voluntary homes and therefore had a responsibility to assure themselves of the care provided to those children. The HSCB accepted in this regard that the voluntary children's homes used by welfare authorities in this period were too large, and due to their size and institutional nature were not conducive to providing a homely environment for children.[41] It also made a specific concession that the routine moving of boys on from Nazareth Lodge to Rubane when they reached secondary school age, largely dependent on their performance in the transfer examination, was not in keeping with the legislative requirement imposed on welfare authorities under section 89 of the CYP Act 1950. This section required welfare authorities to exercise their powers with respect to children in their care so as to further their best interests and to afford them opportunity for the proper development of their character and abilities.[42]

40 GOV 657.
41 GOV 650.
42 GOV 653.

56 However, the HSCB pointed out that while social worker witnesses to the Inquiry spoke about the institutional nature of the care provided in large voluntary homes they also said that they considered the homes provided a satisfactory standard of physical care and that the children were safe. They also referred to the renovations that were made over time to voluntary homes to improve living conditions for children, such as the creation of smaller living units.

57 The HSCB argued that given the range and scope of the statutory duties and powers placed on the MoHA in relation to the regulation of voluntary children's homes, including powers to limit the numbers of children in a home and remove registration if mandatory regulations were not being complied with, it was reasonable for the HSCB's predecessor bodies to take a voluntary home's registration as assurance that it met basic standards of care.[43]

58 We accepted this point and agreed that regulation properly applied by the MoHA should have enabled welfare authorities to rely on a voluntary home's registration. Nevertheless, it is the case that welfare authorities placed children in homes such as Rubane, Nazareth Lodge and Termonbacca at times when they were clearly overcrowded, had inadequate facilities and low staffing levels, and we consider those circumstances should have led them to question whether it was appropriate to place more children in those homes. We recognised that in some circumstances there may not have been any viable alternatives, but that should have spurred the welfare authorities to consider how to require and support improvements in the homes they used in order to protect and promote the well-being of the children they placed in them. These conclusions are set out in the chapters dealing with these homes.

59 As part of the Warning Letter process the HSCB stated that the placing of children in these homes was the responsibility of individual social workers and that they would not have been privy to information as to the number of children, staffing levels and overall facilities in the homes. We did not accept this response. When children were received into care by a welfare authority, whether on a voluntary basis or as a result of a court order, they were placed in the care of the corporate body not the individual social workers who made the practical arrangements for their reception into care. It was therefore the corporate body that was responsible for their ongoing

43 GOV 668-669.

care. While social workers acted on behalf of welfare authorities they did so within management structures and would have had to seek approval for the placement of children in voluntary homes not least because of the financial implications of such placements. Also, while their concern was the well being of individual children there were examples, which we have referred to, where social workers reported general concerns about practices or conditions in voluntary homes and allegations of physical abuse to their senior managers. We recognised that welfare authorities did not have a regulatory role in relation to voluntary homes but this did not mean that they had no responsibility to consider the adequacy and suitability of the placements they were using and the facilities they were paying for.

60 There were examples of welfare authorities taking appropriate action in response to concerns raised about voluntary homes. For example, in 1964 when County Down Welfare Authority received allegations from a boy they had placed in Rubane that he was being sexually abused in the home they promptly referred the matter to the police and the MoHA. The Belfast Welfare Authority, which also had boys placed in the home, was informed about the allegations, and a senior member of staff from that authority visited the home to assure himself that appropriate action had been taken and that the home remained suitable for the placement of boys.

61 Bob Bunting succeeded Mr Moore as Children's Officer in Belfast Welfare Authority in November 1971. He told us that in that role he received a copy of three monthly review reports of all the children in the authority's care who were accommodated in residential care. He explained this meant he was informed about standards of care in the voluntary children's homes used by the Belfast Welfare Authority. He told us that he raised any concerns about the care being provided in a voluntary home with the officer in charge of the home and raised any significant concerns with the MoHA.[44]

62 We saw evidence of this when it came to Mr Bunting's attention that Nazareth Lodge had allowed couples to visit children and take them out of the home without prior assessment of their suitability. He informed that home and other voluntary homes that couples and families had to be approved by the Belfast Welfare Authority before they could take out children who were the responsibility of that authority.[45]

44 RUB 5567.
45 RUB 5569.

The period 1972 to 1995

63 The early 1970s saw significant changes being introduced to the structures for the delivery of statutory social services and the arrangements for the regulation of residential care services. In December 1969, Brian Faulkner, the then Minister for Development for Northern Ireland, initiated a review of the organisation of local government in Northern Ireland. The report of the review, known as the Macrory Report, was published in June 1970. It recommended a major reorganisation of local government in Northern Ireland, including the reduction of the number of local authorities from 72 to 26 and the integration of health and social services. To achieve this integration it recommended that hospitals, community health and social services should be organised as a single system through the creation of four Health and Social Services Boards (Northern, Southern, Eastern and Western Boards).

64 This recommendation was accepted and then developed by consultants Booz-Allen and Hamilton and published in a report dated February 1972 called *An Integrated Service: The reorganization of health and personal social services in Northern Ireland*. In this report the respective role and responsibilities in the new integrated health and social services were described as:

> "The Ministry of Health and Social Services should be responsible for overall objectives, policies and resource allocation...the Area Boards for planning and monitoring of services and District Units for managing and delivering services."[46]

65 The Health and Personal Social Services (NI) Order 1972 (the 1972 Order) established the Health and Social Services Boards (the Boards), which replaced welfare authorities. From 1 October 1973 the Boards operated through a structure of Districts that delivered the services at a local level.

66 The Departmental responsibility for regulation of residential childcare services also changed at this time. The provisions of the CYP Act 1950 in relation to the powers of inspection by the MoHA had been re-enacted through Sections 130 and 168 of the Children and Young Persons Act 1968 (CYP Act 1968). In 1971, the MoHA's two children's inspectors, while retaining their functions in respect of the MoHA, became part of the Social Work Advisory Group (SWAG) within the then Ministry of Health

46 FJH 20634.

and Social Services under the direction of a Chief Social Work Advisor.[47] The Departments (Transfer of Functions) Order (NI) 1973 transferred the remaining functions of the MOHA under the 1968 Act to the Department of Health and Social Services (DHSS) including responsibility for the registration of voluntary children's homes.

67 The CYP Act 1968 had removed the requirement for welfare authorities to have the post of Children's Officer and the HSCB suggested that this created a lacuna in the allocation of responsibility for statutory visiting of children's homes until the DHSS issued the Conduct of Children's Home Direction (Northern Ireland) 1975. Bob Bunting told us that he had to make provision for these responsibilities to be covered within the EHSSB until they were again regulated for in 1975.

68 The DHSSPS disagreed that this lacuna was created and stated that statutory regulations for monthly visiting of statutory children's homes continued to be in force between 1968 and 1975. The DHSSPS also pointed out that the evidence provided by the EHSSB to the Hughes Inquiry showed that in the period 1963 to 1973 the statutory duty for visiting children's homes was delegated from the Children's Officer to other members of the Residential and Day Care management team and that this delegation continued after re-organisation.

69 The Conduct of Children's Home Direction (Northern Ireland) 1975, referred to above, set down revised requirements for the monitoring of statutory children's homes and hostels to reflect the new organisational arrangements and reporting structures in Boards. Section 3(3) required a Visiting Social Worker to visit a home at least once in every month and to submit a report in writing through the District Officer to the Director of Social Services. The Director of Social Services had the responsibility to bring any matters of concern or interest arising from these reports to the attention of the Personal Social Services Committee. In addition, under Section 3(2) of the Direction, a member of the Personal Social Services Committee was required to visit each children's home at least once in every quarter to satisfy her/himself that the home was conducted in the interests and well-being of the children and to report back to the Committee. These monitoring activities were expected to focus on the overall standards of care and practice in the homes rather than the individual well-being and progress of individual children.

47 SND 15665-15666.

70 The HSCB accepted that each Board devised its own approach to meeting the monitoring requirements and that for around ten years after re-organisation no Board had developed written guidance for those undertaking the monitoring. The HSCB also accepted that generally there had been a failure to consistently meet the statutory requirements placed on Boards to monitor their children's homes.

71 However, in accepting this failure it pointed to its reading of the Hughes Inquiry in this respect that visits by Personal Social Services Committee members and line managers were unlikely to detect homosexual abuse in the absence of a complaint or seeing a physical representation of the child. The HSCB went on to submit "The Board considers this would equally extend to other forms of abuse."[48] We did not accept this conclusion. We agreed that because of its nature signs of sexual abuse would have been hard to detect. However, we considered that it would have been possible for appropriately trained visitors who visited a home regularly and maintained consistent contact with the children to detect signs of neglect and possibly to pick up signs of intimidation, fear and physical abuse.

72 We also questioned the effectiveness of the monitoring that did take place. We are in no doubt that the WHSSB took a conscientious approach to monitoring of its children's homes by senior managers and members of its Personal Social Services Committee and that their findings were recorded and reported. A significant amount of time and effort was put into these monitoring activities and pertinent issues were identified. For example, the impact that emergency placements and lack of appropriate placements for children to move on to had on Harberton House's ability to meet its remit were clearly identified, and the adverse effects on the children resident in the home were clearly understood. However, these circumstances were not effectively addressed. Also, despite monitoring of Kincora, from May 1958 when the hostel opened until September 1964, the warden was the only member of care staff and was expected to work for long periods by himself with very limited time off. We consider that the effort expended in monitoring and the costs entailed are only justified if the monitoring actually has a positive impact on the operation of the home and the quality of care provided to the children residing in it. Otherwise the activity could become an end in itself and give a false sense of assurance that the context, facilities and practices in a home were being adequately attended to.

48 GOV 649.

Sheridan Report

73 A significant review of the regulation of children's homes was undertaken in 1982 as a result of the uncovering of sexual abuse of boys in the Kincora hostel run by the EHSSB. The then Secretary of State for Northern Ireland, Mr Prior, told the House of Commons, on 18 February 1982, that while police investigations and trials into the abuse of boys in Kincora were not yet complete he was seeking immediate advice and assistance from the relevant department in England to ensure that all appropriate steps were taken to improve the supervision and management of homes and hostels for children and young persons. Subsequently, a three-person team led by Miss Sheridan, Deputy Director of the Social Work Service, was appointed. The team focussed on:

(a) the overall position and role of the Department in relation to children's homes;

(b) in particular the extent and nature of the Department's responsibilities for inspection and supervision;

(c) what additional steps the Department has been able to take since 1980 to improve or cause to be improved aspects in (ii);

(d) what would be possible and necessary for the future, and in particular whether any clarification of roles was necessary or any additional help required.[49]

74 In the opening comments of her report Miss Sheridan set out her understanding that when SWAG was set up in 1971 it was not able for some years to recruit staff with up-to-date knowledge, experience and qualifications in childcare. She commented that this situation reflected the challenges faced by the Boards when they were set up in 1973, in that they only had a limited number of trained childcare officers, and in common with the rest of the UK had only a tiny proportion of trained residential childcare staff. Miss Sheridan observed that the staffing position in SWAG had recently been strengthened with the appointment of advisers, qualified and experienced in all aspects of childcare.

75 Miss Sheridan's report was provided to the DHSS in Northern Ireland in June 1982, and Miss Brown provided a follow-up report to the DHSS in July 1983 analysing what action had been taken in response to the Sheridan Report. She reported that as of 9 July 1983 (some three and a half years after

49 HIA 641.

matters came to light in Kincora) 42 of the 60 residential childcare facilities in the province had been inspected, and the remaining eighteen homes were still to be inspected. Reports of nineteen of the completed inspections had been submitted to the DHSS and the remaining twenty-three were in the course of preparation. Five follow-up visits had been completed.

76 Following consideration of Miss Brown's report the Permanent Secretary of the DHSS, Mr Dugdale, wrote to his Assistant Secretary, Mr Wilson:

> "...there is clearly a lot going on within the Department on these matters and there are also some indications of a positive response by the agencies in the field. This is all to the good. But I am concerned at the length of time which the whole operation is taking. Especially if – which is by no means beyond the bounds of possibility – the spotlight on Kincora and the other homes where criminal offences were committed swings away from the investigations conducted by the RUC and back to the failings of the child-care system, the Department could be exposed to very damaging criticism for failing to tackle the issues with the urgency that their gravity demands."[50]

77 Mr Dugdale's fears were justified when during the Hughes Committee of Inquiry into Children's Homes and Hostels, the Chief Social Work Adviser, Mr Armstrong, was held to account for the lack of inspection by the SWAG in the 1970s and early 1980s, and the delays post-Kincora in SWAG completing a full round of inspections and follow-up visits to all children's homes in the province.

78 Mr Armstrong had been appointed as Deputy Chief Social Work Adviser in May 1974, before being promoted to the post of Chief Social Work Adviser in August 1983, and he was therefore able to speak from personal experience of the challenges SWAG faced in resourcing inspection activity.

79 He explained that in 1974 the newly created DHSS took over responsibility for the inspection of all residential childcare services with the exception of training schools. It was recognised that the two children's inspectors who had transferred from the MoHA, now called Social Work Advisers, could not cover all the required inspections and an additional Social Work Adviser was appointed in August 1975. It was also decided that inspection reports should contain more detail and a revised format was agreed in February 1976 with a view to having annual reports prepared on

50 KIN 70403.

all children's homes in the province. However, this plan did not materialise because of lack of resources. Just as the additional third Social Work Adviser completed his six month induction period, Miss Forrest retired and it took a year to replace her. As it was not possible for two Social Work Advisers to report on all voluntary and statutory homes it was decided that they should concentrate on voluntary homes.

80 Mr Armstrong explained that SWAG decided on this approach because, in the main, voluntary homes did not have the well defined structures for administration and management of homes that statutory authorities had and it was therefore considered that they needed "more professional attention."[51] In response to this explanation the Hughes Inquiry noted that the only SWAG report extant for Nazareth Lodge for the period 1973 to 1983 related to an inspection carried out in October 1983, which was after the abuse in Kincora came to light, although it accepted that Social Work Advisers had visited the home on four other occasions from 1973. The Hughes Inquiry found this level of inspection to be unsatisfactory, especially in light of Mr Armstrong's evidence that SWAG tended to devote more attention to voluntary rather than statutory homes during the 1970s.[52]

81 Mr Armstrong explained that when events in Kincora were uncovered the approach to inspection was reviewed and it was decided that more detailed inspections of homes were required and a new format of two inspectors spending three to four days in a home was introduced.[53] He confirmed that in the period between October 1980 and March 1984 all the children's homes in the province were inspected.

82 Mr Dugdale's recorded concerns in 1983 about the slow progress in completing the post-Kincora programme of inspections were put to Mr Armstrong, who accepted that even with the inspection team being augmented by two additional inspectors it took considerable time to complete inspections. He also conceded that because the priority was to complete initial inspections, follow-up inspections which were supposed to take place a year after initial inspections to monitor the progress homes had made in meeting recommendations, had been delayed. He explained that this delay in monitoring progress meant that the effectiveness of inspections could not be judged.[54]

51 KIN 70394.
52 HIA 915.
53 KIN 70394.
54 KIN 70406-70408.

83 Mr Armstrong was shown to a memo of 12 May 1980 written by his predecessor, Mr Wilde, in which he indicated that the role of SWAG was seen not so much as regulatory and inspectorial but as promotional and educational in terms agreed in advance with Boards and voluntary organisations. Mr Wilde had commented that this approach had created general misunderstanding and confusion, both in the statutory and voluntary sectors, about the Department's relative powers and the policy of SWAG in exercising them.[55] Mr Armstrong suggested Mr Wilde was referring to voluntary organisations being confused because although the powers of registration and inspection were vested in the DHSS and exercised through SWAG, Boards as the main users of voluntary residential childcare also had to monitor the quality of the care provided. He also indicated that there was similar confusion in the statutory sector about the inspectorial role of SWAG vis-a-vis the monitoring role of the Boards.

84 Mr Armstrong accepted that the term 'inspection' had fallen into disuse and there had been more emphasis on discussion and provision of advice. However, he emphasised that the power of inspection remained with the DHSS and confirmed that from 1980, under his leadership, it was made very clear that SWAG was undertaking inspections.[56] By the time the Hughes report was published in December 1985 all voluntary and statutory children's homes in the province had been inspected and follow-up visits had also been completed.[57]

85 In response to criticisms about the lack of inspection activity by SWAG from 1973 to 1980 the DHSSPS told us that during that period the work of SWAG was characterised by wider childcare consultation and advisory responsibilities and periodic visits to, but fewer inspections of, children's homes.[58] It asserted that the retraction of inspection activity was not a gradual lapse into complacency nor a dereliction of duty on the part of the DHSS but a change of focus driven by the Seebohm Report, which recommended that the role of the inspectorate should be "not so much regulatory as promotional, educative and consultative."[59]

86 The DHSSPS stated that SWAG's consequent change of focus to establishing supportive and advisory relationships with both voluntary

55 KIN 70409.
56 KIN 70411.
57 HIA 965.
58 SNB 9566.
59 Seebohm report Page 197.

and statutory providers of residential childcare services and assisting the DHSS in the social work aspects of its functions was implementing a Departmental policy approach that was part of a UK-wide Government policy on creating new relationships with local providers.[60] [61]

87 During the Inquiry, Dr Harrison, on behalf of the DHSSPS, communicated with Sir William Utting, a former Social Services Inspectorate Chief Inspector for England and Wales, about this shift in focus. Sir William was the Director of Social Services from 1970 to 1976 for the Royal Borough of Kensington and Chelsea and he recalled that at that time statutory children's homes were not inspected but that the Social Work Service (SWS), the English equivalent of SWAG, visited voluntary children's homes.

88 Dr Harrison also contacted David Gilroy CBE, former Deputy Chief Inspector of the SWS. Mr Gilroy confirmed that although the SWS did not systematically visit or inspect statutory children's homes between 1976 and 1985 it did visit voluntary children's homes under the powers of inspection vested in the Secretary of State. He explained that these visits were conducted in an advisory, supportive and developmental style, but that following each visit, a report on the home was forwarded to the Child Care Branch within the English DHSS. These reports were not shared with the administering authorities of the homes or local authorities, but a follow-up letter providing feedback on the visit was sent to the home's administering authority. Mr Gilroy explained that if issues of concern or matters requiring further attention were identified, SWS, with the agreement of the Child Care Branch, would undertake a further visit to the home or take such other action as deemed necessary.[62]

89 The DHSSPS accepted that the DHSS's explanations to the Hughes Inquiry for lack of inspection of children's homes focussed on resourcing issues and commented:

> "It would appear, however that the implications of the Seebohm report for the intended role of SWAG were either not known or not communicated by personnel who provided evidence to the Inquiry."

90 We were not persuaded by the DHSSPS's explanation for the lack of inspection. No documentary evidence was provided to support it except that Mr Wilde used similar language about inspection in his memorandum

60 GOV 003.
61 SNB 9570.
62 GOV 1300.

referred to above as that used in the Seebohm report. The DHSSPS indicated:

> "...Whilst Mr Wilde was plainly familiar with the Seebohm terminology he was seemingly unfamiliar with the policy context."

We found it inconceivable that Mr Wilde, as the Chief Inspector, would be unfamiliar with the policy context for inspection. We also noted that there was no reference in the Sheridan Report to a deliberate change of policy in relation to inspection. Moreover, Mr Armstrong, who held senior positions in SWAG from 1974, told the Hughes Inquiry that the lack of inspection activity, and in particular the failure to implement the policy of annual inspections agreed in 1976, was due to a lack of resources. We consider that given Mr Armstrong's role and his length of service with SWAG he would have been knowledgeable about the policy background to inspection and competent to explain it. Also, as referred to above, in an internal SWAG report of May 1980, about a new approach to inspection, it was recognised that advisers had not been able to devote sufficient time to each home to allow them to engage in thorough inspections.

91 The DHSSPS did go on to concede in its submission to this Inquiry about finance and governance matters that:

> "Had the agreed appropriate action been taken in 1976 to strengthen DHSS scrutiny, this might have helped minimise further opportunity for abuse to occur within children's homes."[63]

We accepted and agreed with that concession. As part of the Warning Letter process the Department of Health (DoH), the successor department to the DHSSPS, reiterated the explanation that the policy developed in the early 1970s of 'visiting' children's homes as opposing to conducting regular annual 'formal inspections' of homes was adopted as a result of the proposals contained in the Seebohm report. The DoH accepted that the DHSS's decision in 1976 to amend this approach and adopt a policy of visiting and making a full report on all children's homes annually was not implemented between the years 1976 and 1981 and that this was a systemic failing. However, it stated that whilst visits by SWAG were aimed at providing professional advice to homes they also included a degree of scrutiny including consideration of poor practice and encouragement towards best practice and that therefore it would not be right to suggest that the concept of 'inspection' was abandoned.

63 GOV 784.

92 However, our view that the move away from annual inspection visits was a resource issue and not the result of a change of policy in response to the Seebohm report was strengthened through consideration of an internal DHSS paper dated 28 May 1980, which was contained in a DHSS file we received from PRONI. The purpose of the paper was to consider a new programme of inspections of children's homes and training schools and to clarify the inspection process, including the methods to be used and the format for reports. The existing approach to regulation of children's homes was outlined in the introduction to the paper:

> "Social Work Advisers (Child Care) visit and write reports on voluntary and statutory homes as part of their normal duties. The reports are in the main concerned with material provisions, management, regimes and support services. They may give some impression of standards of care but our advisers have not been able to devote sufficient time to each home to allow them to engage in a thorough inspection. This paper attempts to formulate a plan for regular inspections of all homes by the Department's advisers."[64]

We consider that it is clear from this contemporaneous DHSS paper that lack of resources rather than policy direction was the reason for reduced inspection activity.

93 We do not underestimate the demands on the limited number of staff in SWAG in the 1970s and early 1980s and recognise that they were contributing to policy developments and consultations at that time as well as maintaining some limited contact with children's homes. We accept that the visits SWAG made to children's homes meant that the children in those homes had the benefit of some external scrutiny of the conditions they were living in and the care they were receiving. **However, as will be clear from our findings in relation to individual children's homes we found the lack of inspection by SWAG in this period amounted to a systemic failing by the DHSS to ensure these homes provided proper care.**

64 GOV 35012.

Implementation of other recommendations in the Sheridan Report

Respective roles and responsibilities in inspection and monitoring

94 The Sheridan Report confirmed the view of Mr Wilde that the respective roles and responsibilities of the DHSS and the Boards in supervising and inspecting statutory homes required clarification. It also identified that clarification was required in relation to the monitoring of voluntary homes, including the role of Boards in exercising satisfactory supervision of the care of children they placed in voluntary homes. The report suggested that achieving this clarity and developing more effective monitoring by Boards and voluntary organisations would enable the DHSS in the long term to assume a greater element of "monitoring the monitors."[65]

95 In response to these recommendations, the DHSS issued a circular entitled *Monitoring of Residential Child Care Services* on 21 October 1983, in which it clarified that the Boards, as agents of the DHSS, were responsible for the provision of statutory residential childcare services and for monitoring the delivery of those services. It further clarified that the Boards were accountable to the DHSS for the way in which they discharged these responsibilities in terms of the quality, range and availability of services and that the DHSS had to be satisfied that each Board had adequate monitoring arrangements.[66]

96 In order for the DHSS to be satisfied, the Boards were required to submit detailed statements of their monitoring arrangements by the end of 1983 and thereafter to produce and submit annual monitoring statements outlining "the elements monitored, the methods used, the trends observed, the areas of concern identified and the action taken to remedy deficiencies". A list of the "main elements to be monitored" was also provided by the DHSS.

97 We found that these structural arrangements were less straightforward in practice when SSI inspectors were concerned about the WHSSB's plans to close Fort James children's home, and in particular the impact it could have on the other children's home in the immediate area. We noted that in contemporaneous internal SSI documentation about the matter an inspector identified the serious implications the closure would have for

65 HIA 654.
66 KIN 75356.

Harberton House and the structure of residential services within the Foyle Unit of Management more generally.

98 The SSI wrote in relatively strong terms to advise against the planned closure, but this advice was not accepted and the closure went ahead. When it was informed that the WHSSB intended to increase the number of beds in Harberton House to compensate for the closure of Fort James the SSI wrote in even stronger terms to strongly advise against that course of action.[67] The WHSSB responded to explain that the increase in beds in Harberton was an interim measure pending a reduction in the need for residential care stemming from a greater emphasis on preventive work. An inspector described that aspiration as "somewhat heroic, particularly given that the number of foster parents in the Western Board area is declining.[68]

99 The SSI communicated its concerns to the WHSSB's Director of Social Services but when this did not have the desired effect as far as we are aware there was no attempt by the SSI or the DHSS to escalate these concerns to Board level. Also, although, according to the circular, the WHSSB was accountable to the DHSS for the "quality, range and availability" of its residential childcare services we saw no evidence of the DHSS holding the WHSSB to account on the basis of the SSI's concerns. This suggested to us that despite the stated position in the circular there continued to be a lack of clarity in practice about the respective roles of the DHSS and the Boards and the authority relationship between them. We concluded in Chapter 23 dealing with Fort James and Harberton House that in order to avoid intervening too directly in the provision of services neither the DHSS nor the SSI, acting on its behalf, responded as assertively to the WHSSB as they should have, given inspectors' assessment of the adverse implications of the closure of Fort James and the increase in beds in Harberton House.

Continuing disagreement about the respective roles of the boards and department

100 It was also the case that despite the work in response to the Sheridan Report to clarify the roles and responsibilities of the DHSS and the Boards, continued disagreement about them was a significant and consistent feature of the evidence we received from the DHSSPS and the HSCB

67 FJH 40054.
68 FJH 40053.

throughout this Inquiry. For example, the respective responsibilities of the DHSS and the Boards for the overall quality of residential childcare were a continuing point of contention. The HSCB, in its submission in relation to governance, stated that the DHSS held "ultimate responsibility for residential childcare and the children placed therein" and referred to the evidence Dr Maurice Hayes, the Permanent Secretary, gave to the Hughes Inquiry, in which he accepted during questioning that the Department held the ultimate responsibility.[69]

101 The DHSSPS responded to this assertion by describing it as simplistic and referred us to a DHSS circular issued in 2006, Responsibilities, *Accountability and Authority of the Department of Health, Social Services and Public Safety, Health and Social Services Boards and Health and Social Services Trusts in the Discharge of Relevant Personal Social Services Functions to Safeguard and Promote the Welfare of Children*, which set out the legal position between the Department, the Board and Trusts in relation to children. The legal position was that while the State was ultimately responsible as parent of all children, in accordance with the common law principle of "parens patriae", it generally exercised its powers to safeguard and promote the welfare of children by providing the legal authority for responsible authorities to discharge statutory functions on its behalf.

102 The DHSSPS pointed out that the 1950 and 1968 Children and Young Persons Acts placed a duty on Welfare Authorities and then Boards in this regard:

> "Where a child is in the care of a welfare authority, it shall be the duty of that authority to exercise their powers with respect to him so as to further his best interests, and to afford him opportunity for the proper development of his character and abilities."[70]

103 The DHSSPS further pointed out that under the provisions of the 1952 Regulations every Welfare Authority was directly responsible for ensuring that each children's home in its charge was conducted in such a manner and on such principles as would further the well-being of the children in the home, and that this responsibility was subsequently transferred to Boards. On the basis of this delegation of authority the DHSSPS argued that, rather than assuming direct responsibility for residential childcare,

69 GOV 664.
70 Section 89 (1) of the 1950 Act (HIA 226) and Section 113(1) of the 1968 Act (HIA 372).

the role of relevant Government departments was to ensure the availability of residential childcare services that were adequate and sufficient to promote the social welfare of children who needed them.

104 We accepted the DHSSPS's analysis of the respective roles and responsibilities of Government departments and Welfare Authorities, and then Boards, for the provision of residential childcare. We consider Welfare Authorities and Boards were responsible for protecting and promoting the interests of children in their care, ensuring that the care provided was appropriate to meet the individual needs of children placed by them and for quality and safety of their children's homes. We also consider that the Administering Authorities of voluntary children's homes and in particular the congregations that ran some homes, were responsible for the quality of care provided and for protecting the interests and promoting the welfare of the children resident in them. As will be clear from a number of chapters dealing with individual voluntary and statutory institutions we were critical and found systemic failings in how these responsibilities were carried out at times.

105 However, we also consider that Government departments had an over-arching and ultimate responsibility to ensure that the authorities to whom it delegated functions undertook them in a responsible and effective manner. Registration and capital funding of voluntary children's home, inspection of all children's homes and consideration of strategic plans for childcare including the development and changing remits of children's homes, were important elements in meeting that over-arching responsibility. Also, in addition to the department's overall responsibility for preparing legislation, regulations and policies, it was important that they kept abreast of developments in professional practice and ensured that new thinking was promulgated to the services.

Monitoring of voluntary children's homes

106 The *Monitoring of Residential Child Care Services* circular also clarified that while Boards retained responsibility in law for the children they placed in voluntary homes, and should have satisfied themselves about the standard of care being provided to each child they were not responsible for monitoring the overall standards, either professional or material, of voluntary homes. However, it recognised that Boards needed to receive information about the professional standards of care and the quality of facilities in voluntary homes in order to help them assess the suitability of a home as a placement for a child in their care. Therefore, it stated

the intention that the DHSS would hold discussions with voluntary organisations about how best this information could be shared. These discussions took place and by the time the Hughes Inquiry reported to the DHSS in December 1985, SWAG reports on voluntary children's homes were being shared with Boards.

107 The circular provided that voluntary children's homes were also required to review their monitoring arrangements and to submit a statement on them. They were specifically required to confirm their arrangements for monthly visiting of the home.

Co-operation between voluntary homes and boards

108 The Sheridan Report also recommended that the DHSS should seek to build up effective co-operation between voluntary homes and between them and Boards in providing residential childcare services.[71] In response to this recommendation the DHSS issued a discussion paper on 23 December 1983 to Boards and voluntary organisations providing residential childcare on *The Statutory/Voluntary Relationship in the Provision of Residential Child Care*. In light of comments received on the initial discussion paper the DHSS issued a formal consultation paper on the same subject on 18 January 1985.[72] The consultation paper and the covering letter set an agenda for discussions between Boards and the Management Committees of voluntary homes and asked for a joint report to be submitted by the end of July 1985 endorsed by the Board and the relevant Management Committee(s) outlining the issues discussed and the solutions proposed.[73]

109 Joint reports were submitted within the set timescale by the Southern, Northern and Western Boards, but the EHSSB was only able to submit an interim progress report because it had not been able to reach agreement with voluntary bodies about significant matters including the level of per capita payments the Board should pay in respect of children it placed in voluntary children's homes. The EHSSB's final report was not received until December 1988, but showed that considerable progress had been achieved in resolving the issues that were causing concern including the per capita fees issue, a matter we will consider further in the Finance section of this chapter.[74]

71 HIA 653-654.
72 HIA 4050–4064.
73 HIA 5354.
74 HIA 5354.

Roles and responsibilities in handling complaints from children in care and their parents

110 A continued lack of clarity about respective roles and responsibilities for monitoring and inspecting children's homes was apparent in relation to the development and implementation of a complaints procedure for children in care and their parents.

111 The Sheridan Report recommended that the DHSS should introduce adequate arrangements for consideration of complaints by children in care and their parents about treatment in children's homes. In response, the DHSS completed two rounds of consultation with the Boards, voluntary agencies and organisations representing the interests of staff and issued guidance in May 1985 on a procedure for investigating complaints. This guidance was issued despite the staff side withdrawing from the consultation process because of concerns that the proposed procedure would not provide staff with adequate protection from unfounded allegations of mistreatment. Ms Doreen Brown, the civil servant responsible for developing the guidance, told us that the DHSS had to decide whether to defer publication of the guidance until staff co-operation had been achieved or issue the guidance in the absence of that co-operation. She explained that the DHSS chose the latter option so as not to countenance a potentially open-ended delay.[75]

112 This decision meant that it was then up to the Boards to reach agreement with the staff side about the development and implementation of a complaints procedure. The Boards worked together to reach agreement with the staff side but it took until January 1990 for the complaints procedure to be agreed.[76] If the DHSS had managed through the consultation process to reach agreement with the staff side before it issued the guidance, that would have greatly assisted the Boards to develop the detail of their own operational arrangements and implement them in a timelier manner. However, we considered the DHSS was right to issue the complaints procedure when it did in order to maintain momentum in the implementation of an important safeguard for children in residential care.

113 In its response to the Warning Letter process the DoH emphasised that the DHSS did not stand back from seeking to assist the resolution of the dispute between Boards' management and staff side. It explained

75 SNB 9043.
76 GOV 822.

that such was the DHSS's concern that in January 1986, the Permanent Secretary, Dr Hayes, issued to the Boards a set of principles for safeguarding the rights of staff against whom complaints were made. In the covering letter Dr Hayes requested the Boards to incorporate the principles into their internal procedures for handling complaints.[77] Dr Hayes also noted his appreciation that the Boards might face some practical problems incorporating these principles into a detailed procedure for investigating complaints. He therefore asked the Boards to review the operation of their procedures for investigation of complaints one year after implementation and advise the DHSS whether operation in accordance with the Hayes principles had caused difficulties in particular cases. This suggests that Dr Hayes may have been hopeful for an earlier resolution of the dispute. The DoH confirmed that the Hayes principles were incorporated into the complaints procedure issued in January 1990 which had been agreed with the Social Work Staffs Joint Council which represented the staff side.

114 From the evidence we considered there were clear examples of social workers responding to complaints of children in voluntary homes through addressing issues directly with managers of the home or referring more serious matters to their senior managers. Complications arose when a Board concluded that complaints raised general issues about care practices in a home that had the potential to affect all the children in the home. This was the case in 1981, when the EHSSB referred complaints about care practices in Rubane to SWAG because it considered they raised general issues about the care standards in the home which only SWAG had the over-arching responsibility and authority to investigate. SWAG persisted in the view that it was for the EHSSB to investigate and address the complaints of children it had placed in the home.

115 The guidance on complaints procedures issued in 1985 did not resolve these types of tension and the EHSSB and the SWAG engaged in similar debates in 1985-86 about allegations from three former residents of Nazareth Lodge that they had been abused by staff in that home. These allegations were made after the DHSS issued the guidance about the complaints procedure but before the Boards gained the agreement of the staff side to implement it. These complaints and how they were dealt with are considered in detail in Chapter 9 which deals with Nazareth Lodge.

77 GOV 956.

116 The relevant point in relation to governance was the fundamental difference in view between managers in the EHSSB and SWAG about who should take responsibility for investigating these complaints. The EHSSB carried out preliminary investigations but concluded that it fell to the SWAG, on behalf of the DHSS, to investigate further since the children making the allegations were no longer resident in the home and the nun who was the main subject of their complaints was no longer working in the home. Also, the EHSSB managers considered that the allegations raised general matters about the care provided in the home that required a wider-ranging investigation than they had the authority to undertake. The SWAG resisted this approach and advised the EHSSB to investigate the complaints in line with the guidance the DHSS had issued about complaints procedures.

117 The EHSSB and the SWAG corresponded on this matter for a considerable length of time but could not agree a way forward. As will be clear from Chapter 9 dealing with Nazareth Lodge we are critical about the use of correspondence as the medium for resolving this complex matter. Given the historical nature of the alleged abuse and the status of the complaints procedure, it was not an effective approach and ultimately resulted in allegations of a serious nature not being fully investigated by a body independent of the Sisters of Nazareth.

118 The circumstances surrounding the investigation of these allegations were raised again in hearings for the governance and finance module, and differences of opinion about respective responsibilities continued to be voiced. In defending the position of its predecessor body, the DHSSPS stated that if concerns about the behaviour of staff in a voluntary children's home, which indicated a need for staff training, supervision or disciplinary action, were brought to the attention of the DHSS it could only encourage an appropriate response on the part of the voluntary organisation since it was not the employing body. It also pointed out that a Board was ultimately responsible for the care and well-being of children it placed in a voluntary home. However, it accepted that if a Board investigated and found the staff problems in a home "to be serious and endemic, the ultimate sanction that the Department would have had at its disposal at the time would have been to de-register the home."[78]

119 The DHSSPS further clarified its position, saying that since at the time the complaints emerged there were no current complaints about the care

78 SNB 9563.

provided in Nazareth Lodge and no grounds to suggest that the alleged abuse had been perpetuated or condoned by staff currently in the home, or that children in the home were affected, the DHSS did not have a locus to investigate. The DHSSPS also emphasised that the DHSS's powers related to inspection and that they had used those powers in Nazareth Lodge in January 1986 and had identified no evidence of any abusive practice historically or currently in the home.

120 Bob Bunting, who was involved at the time the allegations were made, told us it was wrong of the DHSS to expect the EHSSB to investigate concerns about children no longer resident in the home using a complaints procedure which had not been agreed. The HSCB reiterated this point and stated that the EHSSB was being directed to implement a complaints circular that was not fit for purpose at the insistence of the DHSS, and that no system failure should attach to the Board.[79]

121 It was clear from the wealth of documentation we received, including statements provided after the close of public hearings, that strongly opposing views are still held about the apparent rights and wrongs of the positions adopted by the EHSSB and the DHSS in relation to who was responsible for investigating these allegations. The DHSSPS did acknowledge that if SWAG had convened a meeting between the key players at the time, including representatives of the EHSSB and the Administering Authority for Nazareth Lodge that could have helped to achieve an agreed way forward.[80] We agreed with this as we considered SWAG had the ultimate responsibility to ensure these matters were properly investigated.

Review of registration

122 As the Registering Authorities, the MoHA and then the DHSS had powers to review and if necessary remove registration of voluntary children's home. As indicated above, we were only aware of two occasions when active consideration was given to removal of registration. Up until the mid-1980s there was no formal process for registration to be reviewed. Inspection of children's homes was the only vehicle for consideration of continuing suitability for registration, therefore lack of inspection also meant lack of review of registration.

79 GOV 674.
80 SNB 9563.

123 However, as part of strengthening monitoring arrangements in response to the Sheridan Report the DHSS introduced an annual review of registration. Mr Buchanan of the DHSS wrote to the Management Committee of each voluntary home on 10 May 1985 asking for the provision of factual information about the home and indicating that SWAG would be in touch to arrange for an inspection of the home. Mr Buchanan explained that consideration of the factual information and the outcome of inspections would enable the DHSS

> "…to consider on an annual basis the quality of provision and services existing in each home, and, in its capacity as registering authority, to satisfy itself that there was no impediment to the continued registration of the home concerned."[81]

124 Subsequent to 1985, DHSS officials and representatives from the SSI held annual meetings with each voluntary organisation and Board to discuss the annual monitoring information that they had submitted. The DHSSPS pointed out that the meetings with voluntary organisations were termed "Review of Registration" thereby signalling that suitability for registration was being kept under continuing review.[82] We considered the introduction of review meetings to be a welcome and necessary means of providing more focus to the governance of voluntary children's homes for the providers of the care and the regulators of that care.

Inspection of residential childcare

125 On 22 March 1985 the Department wrote to the Boards to announce annual focussed inspections of children's homes and hostels and full-scale inspections every five years. The agendas for both types of inspections were detailed and included annual consideration of compliance with regulations/directions, examination of statutory records, and monitoring arrangements.

126 The Department also announced that the annual inspections would be preceded by discussions with each Board about its policy and procedures in relation to residential childcare, which would then be the subject of a separate report. Similar inspection arrangements were put in place for voluntary homes.

81 SND 9150.
82 GOV 801.

127 The DHSS issued the Hughes report for consultation on 30 April 1986. It contained fifty-six recommendations to improve, inter alia, the operation of homes, the recruitment, pay, terms and conditions and training of staff and the internal monitoring and external scrutiny of the quality of care being provided to children in homes. The report was critical of the lack of inspection of children's homes by the SWAG but recognised that post Kincora the DHSS had strengthened the focus on inspection and the SWAG had inspected all children's homes.

128 The DHSS confirmed in its detailed response to the recommendations in the Hughes report that it had formally designated the Administering Authority of each voluntary children's home and in turn these Authorities had formally designated the person who was visiting the home on their behalf. It further confirmed that voluntary agencies had been asked to implement the recommendation that written guidance should be provided for those undertaking statutory monitoring visits.[83] With regard to inspection of voluntary homes it confirmed that the written reports of designated visitors would be required to be open to inspectors.[84]

129 The DHSS also confirmed that it accepted and had asked the Boards to implement recommendations for strengthening their internal monitoring of children's homes, such as ensuring that statutory visits by PSSC members involved informal contact with children, and that the outcomes of these visits were included in the annual monitoring statements submitted to the DHSS.

130 The DHSS accepted recommendations about inspections by SWAG, such as that all inspections should involve a sample scrutiny of children's personal files to ensure that social work visits and reviews were regular. In response to the recommendation that the SWAG inspection programme should include unannounced visits and significant matters arising should be recorded and pursued, the DHSS stated that it did not consider that unannounced visits need to become a feature of the inspection programme but pointed out that the authority to carry out such visits existed and could be exercised if circumstances arose which demanded it.[85]

131 In 1986, the SWAG, in collaboration with the Board's Assistant Directors of Social Services agreed a comprehensive set of standards for residential childcare. This was the first time that an explicit statement of practice and

83 HIA 4322.
84 HIA 4317.
85 HIA 4323.

professional criteria was issued.[86] Also in 1986, the SWAG was renamed the Social Services Inspectorate, thereby confirming its inspectoral remit and focus.

132 From 1987 the frequency of inspection of statutory children's homes was reduced to every three years. The DHSSPS told us this decision was based on the DHSS having required Boards to strengthen their monitoring of their residential childcare services; submit annual monitoring reports on these services to the DHSS and inform the DHSS about any untoward incidents in their children's homes.

133 While we accepted this rationale, we also considered that this change in approach was probably prompted to some extent by resource considerations and the capacity of the SSI to annually inspect all children's homes.

134 In 1994 the SSI further developed standards for inspection and monitoring of children's homes: *Quality Living Standards for Services: Children who live away from Home*. On 26 May 1995 the Department issued a circular *Monitoring of Residential Child Care Services* which modified and consolidated the arrangements for the monitoring of residential childcare services and introduced new standards for the inspection of such services.[87] It was the framework within which a programme of annual inspections of voluntary children's homes (including two unannounced visits) and three-yearly inspection of statutory children's homes was conducted by the SSI.[88] The DHSSPS told us that this programme included a strong emphasis on the need for inspectors to speak directly to children and seek confidential feedback from children and their parents regarding aspects of the care in the home.[89]

135 In 1996 the inspection of children's homes was transferred from the DHSS to the Boards' Regulation and Inspection Units, which had been established in 1994 and were subsequently transferred to the Regulation, Quality and Improvement Authority under the provisions of the Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003.

86 SND 15667.
87 HIA 7305.
88 SND 15667.
89 SND 15667.

Regulation of training schools and criminal justice institutions

136 The responsibility for inspection of training schools transferred from MoHA to the Northern Ireland Office (NIO) in 1974, and the NIO vested its powers of inspection to the SWAG as the DHSS had done in relation to other types of residential childcare. The lack of inspection by SWAG affected the training schools as it did the children's homes, but we found it was compensated for to some extent by the consistent attention of the Training School Branch of the NIO, whose officials maintained a high level of contact and oversight of the training schools. Although the establishment of the Ministry (later the Department) of Health and Social Services and its responsibility to provide and secure the provision of personal social services in Northern Ireland was legislated for through Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1972 the formal transfer of duties from the MoHA to the DHSS did not take effect until 1 January 1974. The responsibility for provisions relating to young offenders was also assumed by the NIO at that time.[90]

137 NIO officials held regular meetings with senior managers and representatives of the Boards of each of the training schools. The minutes of these meetings that we saw showed that although there was a focus on financial and administrative issues, there was also discussion of policy developments, legislative change and particularly serious concerns that the schools had about managing the behaviour of particular children and on occasion the conduct of members of staff.

138 From the evidence we heard it appeared that training schools and criminal justice institutions were generally better resourced than children's homes, and the NIO appeared more open and quicker to respond to requests for additional funding. This more favourable position was evident in the level and qualification profile of staff. SWAG inspectors found that staffing levels across the four training schools were generally satisfactory, and although shortfalls did result in some overtime working, temporary staff were also employed to assist at such times. Inspectors also found there had been an extensive programme of secondments to full-time qualifying training in the late 1970s and early 1980s. Several senior staff had completed a post-qualifying course and most of the schools had a policy of recruiting professionally qualified staff to fill vacancies as they arose. The DHSSPS

90 GOV 10004-10005.

indicated to us that overall the staffing ratios in the training schools in 1989 compared favourably with, and may well have represented an improvement on, the ratios that existed in a number of children's homes at that time.[91]

139 The more rigorous approach to inspection post Kincora and Hughes was also extended to training schools. In 1991 a more formal arrangement for inspections, including formal arrangements for the funding of inspection activity, was agreed between the NIO and the DHSS and a draft paper was considered setting out expectations for SSI inspections.[92] This included that the SSI should advise the NIO, inter alia, on control and aftercare issues in training schools. The SSI agreed with the NIO that each training school would receive two unannounced visits each year. Inspections were to be undertaken every four years, interspersed by more frequent less intensive reviews referred to as "regulatory inspections",[93] and an annual monitoring report was to be submitted by the Director of each training school to the Management Board, the NIO and SSI based on the format introduced for children's homes.[94]

140 In addition to holding responsibility for training schools the NIO was responsible for Hydebank, which was a Young Offenders Centre opened in 1979 and operated under the provisions of the Treatment of Offenders Act (Northern Ireland) 1968 (the Act). The Governor of Hydebank reported to the Director of Prison Operations in the Northern Ireland Office (NIO) and we were told by a former Governor, Mr Murray, that the Director in his time, Mr Kendrick, would make frequent visits to Hydebank, and carried out rounds of the establishment to satisfy himself that everything was in order.[95] We were also told that officials from the NIO Treatment of Offenders Branch were frequent visitors to Hydebank and attended a number of routine meetings and that, for example, an official from the NIO chaired the meetings that determined whether a boy should be trusted with orderly status.[96] In addition, as part of the arrangement whereby the HM Chief Inspector of Prisons for England and Wales (HMCIP) inspected one prison in Northern Ireland each year, Hydebank was inspected by HMCIP in June 1982 and again in October/November 1994.

91 RGL 1355.
92 RGL 1357.
93 RGL 1358.
94 RGL 1357.
95 HYD 484.
96 HYD 513.

141 We found that the level of direct contact between NIO officials and criminal justice establishments was helpful in relation to funding and policy issues and in enabling the NIO to appreciate the challenges the services were facing. We concluded that more direct engagement by DHSS officials with residential childcare homes could have brought similar advantages.

The impact of organisational change

142 In the evidence it provided for the Governance and Finance module, the HSCB made the point that "from 1973 until 1995, the management arrangements for health and social services were changed repeatedly at the initiative of the Department"[97] and these organisational changes "inevitably impacted upon the stability and development of operational structures as lines of accountability and decision-making had to adjust to fit the new structure."[98]

143 The DHSSPS response to this analysis was that these changes were not introduced on a whim but were the implementation of key UK Government policies aimed at strengthening and improving health and personal social services. It pointed out that such changes normally followed consultation by its predecessor bodies, which included consideration of the practical implications of proposed changes, and that it was the responsibility of Boards to ensure that lines of accountability were clear and to provide training and guidance to their staff to ensure that they could fulfil their roles in a responsible and effective manner.[99]

144 We accepted that new structures were introduced with the intention of improving the delivery of services, but considered that the HSCB made a valid point about the disruption and distraction caused by reorganisations. It was clear from the evidence we heard that the transfer of responsibilities from welfare authorities to Boards took some time to settle down. This situation was made more complex when it involved a multi-professional staff group working in one small unit, as was the case in Lissue Hospital.

145 We considered Lissue Hospital in relation to the residential care it provided to children. We found that following re-organisation it ended up in 1973 with a situation whereby nursing staff were accountable to a Chief Administrative Nursing Officer, based in Lisburn, consultant psychiatrists

97 GOV 660.
98 GOV 797.
99 GOV 797.

were accountable to the EHSSB, social workers were accountable to the North and West Belfast Trust and psychologists were accountable to the Royal Group of Hospitals Trust. Witnesses who worked in Lissue told us that this complicated set of governance arrangements resulted in a multiplicity of accountability and communication lines and a lack of overall strategic management of Lissue.

146 Although this is a very particular and somewhat extreme example it does point to the importance of ensuring that the effects of high-level organisational and structural change on the delivery of services, particularly niche services, are fully identified and addressed.

Conclusions about Governance

147 Although the importance of regular monitoring and inspection of residential childcare services was given legislative force, it was not sufficiently or consistently implemented to provide the intended safeguards. We found that a lack of clarity about who was the Administering Authority for some voluntary children's homes meant that required monitoring did not take place and it was not enforced by the inspectorates. Although the structures and arrangements for internal line management and monitoring were generally better for statutory homes, we also found inconsistencies in how monitoring policies were implemented and at times an apparent inability of managers and Committee members to move beyond identifying problems to addressing them.

148 We found that the lack of inspection by SWAG was due to a lack of resources for inspection activities rather than a policy decision. We also noted that while inspectors accurately identified issues and recommended appropriate remedial action, their follow-up to ensure action had been taken was less consistent, even when the same issues were identified through subsequent inspection activity. For example, in relation to Nazareth House, Derry, recommendations about staffing levels, staff structures and deployment of staff were made in 1983, 1986, 1989, 1991, 1992 and 1993, and recommendations about the need for more adequate staff supervision/professional support arrangements were made in 1983, 1986, 1989, 1991, 1992, 1994 and 1995.

149 We also noted a lack of assertiveness in enforcing statutory requirements. We understood the concern to maintain an appropriate distance from service delivery and avoid any undermining of the responsibilities of service

providers. However we considered that at times MoHA and SWAG were not as effective as intended, because as well as not being adequately resourced to carry out their duties in a timely manner, they did not use the authority vested in them to enforce requirements and were not persistent in requiring action.

150 We considered that closer involvement by DHSS officials in the oversight of the scrutiny of children's homes could have led to a quicker realisation that internal monitoring of children's homes needed to be strengthened and that the resources of SWAG needed to be increased in order for external scrutiny to be delivered to an adequate level.

151 However, we recognised that the DHSS responded constructively to the recommendations of the Sheridan Report and the Hughes Report and worked collaboratively with the Boards and voluntary organisations to improve the monitoring and inspection of children's homes. We also recognised that SWAG staff contributed to this work alongside a demanding inspection schedule, and that from that time on there was a significant improvement in the standards of care and practice in children's homes.

152 The DHSS also took a proactive role in increasing the qualification profile of residential childcare staff, including contributing to the costs of staff in voluntary children's homes achieving professional qualifications. This initiative was successful to the extent that in time Northern Ireland had a better level of qualified residential childcare staff than any other country in the United Kingdom.

153 It is also important to acknowledge that statutory and voluntary agencies worked hard to co-operate with these initiatives and did so at a time when they were providing services within very challenging social and economic circumstances, which were exacerbated by the political unrest.

Part Two: Finance

Funding of voluntary children's homes

154 As previously explained, prior to the reorganisation of local government administration that commenced in 1946, the Poor Law system operated in Northern Ireland. Boards of Guardians were responsible for securing the care and welfare of children whose parents or guardians were unable or were deemed unfit to look after them. The majority of voluntary children's homes at that time were run by Roman Catholic religious orders. These homes were established in response to the considerable poverty and need in the Roman Catholic communities and by a desire of the Roman Catholic Church to ensure that children born into that faith were brought up in it. Roman Catholic bishops asked religious orders such as the Sisters of Nazareth and the Sisters of St Louis to run children's homes in the province and the funding of the homes came mainly from public donations and legacies.

155 For example, the Sisters of Nazareth in Belfast and Londonderry depended on the door to door collections made by nuns in the cities and surrounding countryside, which were supplemented by the produce from the farms situated in Nazareth Lodge and Termonbacca and the Government funding granted to these farms. In Belfast, the fund-raising expertise of Brother Stephen Kelly of the De La Salle order contributed greatly to meeting the costs of the care and after-care of boys in St Patrick's and Rubane. However, despite the significant generosity of the Roman Catholic communities towards these homes, the level of poverty particularly in the 1920s to the 1960s, coupled with the commitment of religious orders that those in need should not be turned away, meant that up until the late 1960s many of these voluntary children's homes were overpopulated and under-resourced.

156 It was not only homes for Roman Catholic children that depended on public support and donations. The Irish Church Mission which ran Manor House, a children's home in Lisburn, also depended on public donations and paid two collectors to seek contributions and collect them. When one of the collectors had to resign through ill health and there was a delay in the appointment of her successor the home experienced a significant loss of necessary revenue.

Welfare Authorities contributing to the funding of voluntary homes

157 Following the reorganisation of local government in 1946, County Councils and County Boroughs received revenue funding from various sources, including local rates and government grants and were required to establish welfare authorities. The CYPA 1950 placed duties and powers on these welfare authorities to establish children's homes and to contribute towards the welfare of children they placed in voluntary homes. The DHSSPS explained in its evidence to us that this latter provision marked the beginning of mandated state support to the voluntary residential children's sector.[100] Welfare authorities were also empowered to recover contributions from the parents of children in their care, but their circumstances were usually such that any contributions were negligible.

158 The MoHA maintained an oversight of the financial arrangements between welfare authorities and voluntary homes. While Section 118(2) of the CYPA 1950 enabled welfare authorities to contribute to the costs of care for children they placed in voluntary homes, Section 90(5) of the Act legislated that the MoHA had to approve the rates of payments to be made and that the rates could only be changed with its approval.

159 The CYPA 1950 also provided that the MoHA could provide financial support to voluntary children's homes to assist them to improve their premises and augment their qualified staff. Under Section 119(2) of CYPA 1950, the MoHA recouped 50% of the grants it paid to voluntary agencies for these purposes from the welfare authorities. The proportion of the cost each welfare authority was required to pay was determined on the basis of its population size. The welfare authorities were not happy about this arrangement because they were required to contribute to funding grants which they had no say in approving. They pointed out that this lack of consultation made it difficult for them to predict what element of their budget they needed to reserve each financial year for funding of voluntary children's homes. The welfare authorities were particularly resistant to having to contribute to the funding of homes that were not in their locality and which they were therefore unlikely to use.

160 As explained in the chapter dealing with the Sisters of Nazareth homes in Londonderry, the County Londonderry Welfare Committee was particularly

100 GOV 403.

resistant to these funding arrangements. An internal MoHA memorandum dated April 1953 referred to Londonderry Welfare Committee's description of the arrangements as "taxation without representation" and its request that welfare authorities should be consulted in advance about grant applications.[101] The MoHA decided that since the amounts involved were small the delays that would be caused by consulting with welfare authorities in advance and dealing with any disputes about whether funding should be granted would not be justified, and that therefore the funding decisions should remain in its hands. At a subsequent meeting with the Association of Welfare Committees on 26 February 1954, MoHA officials pointed out that giving grants to voluntary homes was:

> "... more economical than direct provision of new Homes by Welfare Authorities, as the Voluntary Homes do not charge full rate, as they have their own voluntary fund and labour. In fact there was the question as to whether there should not be a halt to the provision of Statutory Homes and the using of more Voluntary Homes."[102]

161 However, in response to the continuing concerns expressed by the welfare authorities, MoHA officials agreed to give them as much advance notice as possible about proposed expenditure in a current year and provisions for the following year, and we saw evidence in the minutes of later meetings between MoHA officials and the Association of Welfare Authorities that this notice was provided. Also, in 1955, the MoHA established the Children's Homes and Training Schools Committee under the chairmanship of Miss Bessie Maconachie, MP:

> "to advise the Minister whether or not the circumstances appear to be such as to call for special financial assistance from public funds under the Act."

The committee contained representatives of the churches, the Child Welfare Council and welfare authorities.

162 It was clear from a memorandum that a MoHA official sent to his Minister in July 1958 that officials were keen for welfare authorities to provide more financial assistance to voluntary children's homes. The official set out his view that Section 118 (2) of the 1950 Act could and should be used more widely:

101 SND 7484.
102 SND 7475.

> "...if the welfare authority feels that the managers of a children's home in their area are, in fact, helping and relieving them indirectly of looking after children, some of whom would otherwise fall to be taken into care and perhaps housed by the welfare authority, and if that Home is finding it impossible to make ends meet it is a legitimate and proper thing, and incidentally good business, to make a contribution to the Home's general funds by a grant under sub section (2)".[103]

163 Somewhat ironically this enabling interpretation of the legislation was provided in the context of the official advising the Minister that the Londonderry County Borough Welfare Council's proposed grant of £1,000 to Termonbacca Children's home to address its serious financial position should not be approved. The official offered this advice on the basis that the accounts provided by the Sisters of Nazareth to support the grant application showed that the home benefitted at times of financial need from loans from its mother house that it was not under pressure to repay. Therefore, he concluded the true financial situation of the home was not sufficiently bad to justify approval of the grant.[104]

164 While recommending that the grant should not be approved the official accepted:

> "...there is no doubt whatever that this Home by its activities has in the past and will in the future relieve the rate-payer and the tax-payer of very considerable sums on Child Welfare, compared with which the proposed grant of £1,000 is a trifle, but, of course, the same thing could be said of a dozen other voluntary organisations in Northern Ireland."[105]

MoHA grants to voluntary homes

165 This approach derived from a fundamental expectation of the Government that voluntary children's homes should be funded through voluntary effort. This was made clear in the guidance provided to voluntary organisations about applying to the MoHA for grants under section 118(1) of the CYPA 1950. That guidance stated:

> "The Ministry does not intend that these grants should weaken voluntary effort by taking the place of voluntary donations and endowments and

103 SND 6006.
104 SND 6006.
105 SND 6009.

it is thought the larger organisations will have adequate income from such sources to meet their requirements. Where for example, an application is made in respect of one of a number of homes run by a voluntary organisation, the resources of the organisation as a whole will be taken into consideration".[106]

166 This requirement that the resources of a whole organisation should be taken into consideration created significant difficulties for Termonbacca in 1959 when approval for funding to make improvements to its accommodation for children was delayed because the Mother House, which was located in Hammersmith in London was reluctant to provide required information about its overall funding situation. This reluctance to provide financial information also contributed to delays in Nazareth House Belfast applying for available grants at a time when the conditions in the home were in dire need of improvement. In Module 1, Sister Brenda McCall on behalf of the Sisters of Nazareth confirmed that in the 1950s and 1960s the Congregation's policy was to maintain complete secrecy in relation to its financial affairs. She explained that only the Superior General and her council would have known what funds the congregation had at its disposal[107] and accepted that the secrecy around finances created delays in homes receiving necessary state funding.[108]

167 Sister Brenda McCall also indicated that sisters may have been reluctant at that time to accept funding from social services for fear that "their voluntary status might be taken off them" or that it would lead to the children not being brought up in the Catholic faith.[109] Former senior managers of social services departments (Bob Bunting and Robert Moore) also suggested that religious orders may have been reluctant to accept grants from the State for fear that could lead to an undermining of their independence and their right to decide on admissions to homes and how they should operate.

168 It was also clear that there was some political reluctance in relation to the provision of grants. For example, when Nazareth House Derry made an application for a grant towards the provision of a new play hall the Unionist MP for the City of Derry, E.W. Jones QC MP, wrote to the then Minister of Home Affairs, G.B. Hanna QC MP:

106 SND 5814.
107 Day 35, pp.170 and 171.
108 Day 35, pp.172 and 173.
109 Day 35, p.205.

> "On further reflection about this matter I am even more strongly convinced that this Grant should not be made at any time but particularly at the present time when public monies should be so carefully guarded."[110]

169 Contemporaneous internal MoHA documentation showed that there was a view that it was inappropriate to fund the development and extension of voluntary homes when statutory children's homes were becoming increasingly available. In a memo of 18 October 1957 a senior civil servant concluded in his report to the then Minister of Home Affairs, Walter Topping, about a meeting officials had with the De la Salle Order regarding plans to extend its home in Rubane:

> "I think the remedy lies with the Roman Church. If it is the determined policy of that Church to foster Voluntary Homes to the exclusion of the Welfare Authorities then they must be prepared to do so at their own expense".[111]

170 While there were difficulties and delays surrounding the provision of government grants to voluntary homes it is important to acknowledge that when they were provided they were used to good effect to significantly improve the design and fabric of homes and increase the facilities available to children. Therefore, it is important to acknowledge that the state increasingly recognised its responsibility to the children in voluntary homes and that led to funding for placements there.

Funding of placements in voluntary children's homes

171 The Child Welfare Committee (CWC) referred to above, published a report *Children in Care* in 1956 in which it was observed that although welfare authorities were empowered to pay maintenance grants for children they placed in voluntary homes this was of limited assistance to many voluntary organisations, as the greater proportion of children in their homes were placed there on a private basis. The CWC concluded that it could not recommend any form of grant-aid for a child placed in a home without reference to a welfare authority because such a practice "would raise problems of policy in relation to the further public control of the management of Voluntary Homes".[112] It recommended that it should be a

110 SND 7503.
111 RUB 10203.
112 HIA 1766.

duty of voluntary homes to seek the advice and help of welfare authorities before admitting a child to a home.[113] It further recommended in its 1960 report *Operation of the Social Services in Relation to Child Welfare* that a period of one month should be allowed following the admission of children on a private basis to a voluntary home, during which time welfare authorities would not regard these children as being 'technically in care' of the voluntary organisation until the question of financial responsibility had been fully discussed.[114]

CWC report *Role of Voluntary Homes in Child Care*

172 The CWC commented in its 1966 report *Role of Voluntary Homes in Child Care* that these recommendations were not accepted because the voluntary homes were concerned that they would interfere with their "essential liberty to admit children privately, confidentially and at their own discretion"[115] and the welfare authorities were concerned they would create difficulties when assessing respective responsibilities. The CWC also noted that welfare authorities were unwilling to co-operate with some voluntary homes because they saw them as too ready to accept children without adequate investigation of their circumstances, and/or they implemented a rigid segregation of age groups and sexes which they considered was inappropriate for many children requiring residential care.

173 The attitudes of parents were also identified as significant. The CWC recognised that parents of illegitimate children in particular might be reluctant to discuss their situation with a public authority. It also acknowledged that some parents were of the view that only a home which operated under the auspices of their own church could ensure their children's religious upbringing.

174 The CWC categorised admissions to voluntary homes under three headings:

- **Non Statutory Cases** – children accepted into voluntary homes by purely private arrangements with their parents or guardians;
- **Quasi Statutory Cases** – children admitted privately to voluntary homes who although not in local authority care, might have been placed in the voluntary homes if the question of their admission had been raised with the Welfare Authority; and,

113 HIA 1765.
114 HIA 497.
115 HIA 556.

- **Agency Cases** – children who were in the care of a Welfare Authority and placed in voluntary homes by it.[116]

175 It provided statistics as of 31 March 1965 which showed that out of a total number of 822 children in voluntary children's homes only 238 had been placed there by welfare authorities; the remaining 584 children had been placed through private arrangements and therefore no state funding was available for their care. A similar picture emerged in relation to the 131 children in the care of voluntary organisations who had been boarded-out; only twenty-one of these children were funded by welfare authorities. This meant that in total only 259 out of 953 children in the care of voluntary organisations were "Agency" children. The remaining 694 children, 32% of all children in care in Northern Ireland at that time, were being cared for on a private basis. The CWC compared this situation to that in England and Wales, where 17% of children were in care on a private basis, and Scotland, where 15% of children were in care on a private basis.[117]

176 To assess the impact of this funding situation the CWC asked voluntary agencies to provide information about their finances, but only received responses from ten homes. Two of these homes said they had adequate resources while the other eight said they had not and were hampered by lack of finance in improving accommodation, providing basic amenities and employing staff.[118]

177 The CWC also noted that even where welfare authorities were paying fees for children they placed in voluntary homes the fees did not cover the full cost of maintaining children in the home and were considerably less than the level of funding required to maintain a child in a statutory home. The CWC advised voluntary agencies to charge the full cost, but observed that in order to do so they would need to get their accounts into order.[119]

178 The CWC concluded:

> "…the solution here lies very largely with the homes themselves: many could get considerably more assistance than they do at present from public funds by early and close liaison with welfare authorities where there is a possibility that a child may be eligible for reception into care". [120]

116 HIA 554.
117 HIA 554.
118 HIA 559.
119 HIA 561.
120 SND 7837.

Welfare Authorities taking responsibility for children placed voluntarily in homes

179 These discussions about the respective responsibilities of voluntary homes and welfare authorities in relation to the reception of children into care continued until the mid-1970s. Increasingly by that time the majority of children were placed in voluntary homes by welfare authorities. However, there continued to be a number of children who had been placed in the homes in previous years on a private basis and whose care was still being paid for by the religious orders running the homes. This was the case in Rubane. In 1971 the financial burden of repaying debt incurred through renovating the home and the increased costs of maintaining the property led the brother in charge, BR 2, to ask relevant welfare authorities to take on the support of the remaining twenty boys who had been placed in the home on a voluntary basis.[121]

180 The Belfast Welfare Authority responded positively to this request, but on the basis of two important provisos: firstly, that the boys' files must be provided so that contact could be made with any families they might have and the possibility of reconnection explored; secondly, it was made clear to the De La Salle Order that in future placements would have to be agreed in advance and that it would not be acceptable for the Order to accept voluntary placements and then expect the welfare authorities to fund them. We considered that these were appropriate provisos which sought to prevent children remaining in care if that could be avoided, and to avoid children being admitted to care without other interventions being explored. The provisos were also in keeping with the philosophy of the 1968 CYPA, which for the first time established prevention as an underlying principle in childcare practice and introduced discretionary powers to provide families with material help as a means of preventing children being placed in care.[122] This was an important principle, as it was clear from the records of voluntary homes we considered that many children were placed on a private basis in homes because their parents were unable to provide for them and, in particular, fathers were unable to work and care for their children when their wives were absent due to ill health or death.

121 RUB 10591.
122 SND 164.

Impact of restructuring of local Government

181 When local government was restructured in 1973 the DHSS retained the legal responsibility for registering voluntary children's homes and for grant-aiding any improvements which involved capital expenditure. Grant-aid was based on Government granting up to 75% of full costs; the voluntary organisation had to fund the remaining 25% of the costs. Also, where grants were funded, requirements were placed on the voluntary organisation that they had to repay all or part of the money if it ceased to provide the relevant service within a certain number of years.

182 The DHSSPS told us that as part of the restructuring of local government the DHSS actively encouraged the newly established HSSBs to support their local voluntary sector. In a Circular published in December 1974 *Support for Voluntary Organisations*[123] the DHSS clarified that its role was to support voluntary bodies that operated at a regional level financially, and that the Boards would be locally responsible for supporting voluntary bodies within their geographic area. The Circular outlined the Boards' statutory powers to make contractual arrangements and make grants with voluntary organisations for the provision of social services and to make available premises, vehicles, equipment, etc to assist voluntary organisations for the provision of social services. The Department clarified that the Boards' annual allocation covered support for voluntary organisations and that it did not propose to earmark funds for these bodies.[124]

183 In the mid-1970s the funding of voluntary homes improved when the HSSBs agreed to move from paying maintenance costs for individual children they placed in voluntary homes to making "per capita" payments, which would include a contribution towards the running costs of the homes. Bob Bunting told us that he took the initiative to introduce this approach in the EHSSB area. He provided us with a copy of a report he presented to the EHSSB which explained the limitations of the previous maintenance fees. These included that they did not cover all costs, and additional grants had to be paid as the need arose, for example to pay the costs of holidays. More fundamentally, since voluntary organisations contributed towards the general running costs of the homes they were "indirectly subscribing to the upkeep of children who were in the care of

123 GOV 523 – 528.
124 GOV 525.

Welfare Authorities".[125] The EHSSB agreed to pay the per capita rate for children who had been placed in Nazareth House and Nazareth Lodge on a voluntary basis, which significantly improved the funding of these homes.

184 The new per capita rate was based on the annual running costs of the home minus the voluntary/charitable income that the voluntary organisation was expected to raise divided by the number of places to be provided by the voluntary home. Bob Bunting explained that the expectation was that the voluntary organisations would contribute up to 5% of the total revenue expenditure.

185 In October 1978 the DHSS wrote to the Boards to inform them that it was giving them greater flexibility to provide financial assistance to voluntary agencies. This greater flexibility included increasing the Boards' authority to pay grants without Departmental approval up to a limit of £25,000 and 90% of expenditure, and giving Boards authority to pay capital grants of up to £5,000 to voluntary agencies without Departmental approval. The DHSS also recognised the need for prompt payment of grant and allowed that, where necessary, a proportion of a grant could be paid in advance on the basis of estimates of expenditure.[126]

186 The Boards reviewed per capita rates annually and, at times, additional allocations for specific needs continued to be made to voluntary homes. Bob Bunting explained that this arrangement worked up until 1980, when a decrease in occupancy levels in voluntary homes increased the per capita maintenance costs. He pointed out that despite a challenging financial climate for the EHSSB, weekly per capita maintenance rates to voluntary homes were increased, and one-off grants were made to cover deficits which had arisen because of low occupancy rates, but even these measures were not sufficient to cover the full operational costs of homes. We saw evidence of this approach; the EHSSB made a deficit payment of £45,000 to Nazareth Lodge for the year ended 31 March 1982 and in 1987 agreed to increase the weekly per capita payment for children placed in the home from £80 to £147 conditional on two additional staff being employed in each of the four groups of children in the home.[127]

125 HIA 5391.
126 SNB 9005.
127 SNB 100126.

The Statutory/Voluntary Relationship in the Provision of Residential Child Care

187 As indicated above, in January 1989 the DHSS issued a discussion paper entitled *The Statutory/Voluntary Relationship in the Provision of Residential Child Care* to Boards and voluntary bodies. As part of the discussions prompted by that paper, EHSSB officers proposed that in order to ensure the financial viability of the voluntary children's homes in its area a fee would be paid for an agreed number of places in each home regardless of occupancy levels but on the basis that the relevant voluntary organisations should contribute up to 5% of the costs of their homes.[128] The voluntary organisations argued that each home's capacity to make such a contribution should be reviewed on an annual basis. They pointed out that they had to bear 25% of the costs of improvements to their homes as a condition of receipt of capital funding grants from Government, and where that applied it would affect a voluntary organisation's capacity to pay a further 5% towards the running costs of the home.

188 When officials found it impossible to agree a way forward in relation to this matter it was referred to the Board, which eventually confirmed its intention to try and meet the total deficits arising from the shortfalls in funding the agreed operational expenditure for the voluntary homes at the end of each financial year, taking into account any contribution from the voluntary home towards the running costs.[129] This compromise maintained the principle of voluntary organisations contributing to the costs while accepting that their ability to do so would depend on the other demands on their available funding. This intention was confirmed at an annual meeting between representatives of the Board and voluntary children's homes held on 12 September 1988.[130]

189 The Sisters of Nazareth in Londonderry experienced similar difficulties when falling numbers in the home increased the cost of overheads. Although the WHSSB increased the weekly per capita rate it paid per child from £88.34 at December 1985 to £173 in December 1987, the homes continued to struggle to meet its costs. The SSI intervened to request the Board to address the financial difficulties experienced by the home, and the Board accepted that the Sisters of Nazareth had a justified case in seeking an

128 HIA 5347.
129 HIA 5381.
130 HIA 5379.

increase in the weekly per capita rate. To assist the situation, the DHSS gave the WHSSB £65,000 in 1987 to provide additional assistance for voluntary children's homes. The WHSSB used £47,642 of this funding to pay off the home's 1985/86 budget deficit, but further additional funding was required in succeeding years to pay off substantial deficits and the Sisters of Nazareth made the case that care in the home was compromised because of lack of funding. In an internal SSI memo written in July 1992 by an inspector, Marion Reynolds, about her visits to children's homes in the WHSSB she recorded that the sister in charge of Nazareth House, SR 2, had written to Dominic Burke to advise him that the quality of care available in the home was being adversely affected by the current staffing levels.[131]

190 In the early 1990s, responsibility for the purchase of children's residential care services was delegated to the newly established Health and Social Services' Trust. Trusts entered into detailed annual contractual arrangements with voluntary sector providers regarding matters such as: the aims and purpose of the home within the Board/Trust's children's services plans; the standards expected of the home; the number of children's places to be provided; and, the rate at which these would be purchased by Trusts. Such contractual arrangements were also based on an expectation that a proportion of the costs of providing the service would be met by charitable income.

Conclusions about voluntary children's homes

191 It was ironic that as the religious orders were able, through the funding they received for weekly per-capita fees and capital grants, to improve the physical conditions and amenities of their large homes, the demand for placements in these homes began to steadily decline. This decline raised the overhead costs of the homes and meant that the orders remained in financial difficulties. The lack of demand for placements was due to a range of factors including: more statutory homes being built; less stigma about single parenthood/illegitimacy, which reduced the number of young children coming into care and consequently reduced the length of time children stayed in homes; smaller families; more welfare assistance for families experiencing poverty; emphasis on preventive work to assist children to remain with their families; a preference for fostering where

131 GOV 35011.

accommodation away from home was required and where residential care was required a policy of accommodating children as close to their own communities as possible. This trend was best illustrated by the case of Rubane, where for years inadequate bedroom and toilet/bathroom facilities existed while discussions about the financing of improvements and what form they should take were ongoing. Not long after the new houses were built some of them had to be shut because of under-occupancy. It was also the case that increasingly the homes were seen as less equipped to meet the challenges of working with the older children coming into care, many of whom displayed disruptive behaviour.

192 We accepted the submission of the Sisters of Nazareth that throughout the period from 1922 to 1995 the Order operated homes under extreme financial stress, which was known to the DHSS, the Boards and their predecessors and that the financial straits under which they were operating had an impact on the quality of care they were able to provide.[132] The same could be said of the De La Salle home in Rubane.

193 We concluded that from the 1920s to the 1960s many children of Northern Ireland were accommodated in large, overcrowded and understaffed homes, some of which had inadequate basic facilities. Staff shortages led to a lack of supervision and dependence on older children to supervise younger children, which created the circumstances in which children were physically and sexually abused.

194 We recognised that Government departments had a responsibility to ensure that public money was spent wisely and that religious orders should have been prepared to provide financial information to support funding applications. It was also the case that children were accepted into voluntary homes when at times there was not sufficient space or resources to care for them properly and where little or no consideration had been given to whether their birth families could have been supported to continue to care for them. However, as will be clear in the chapters dealing with individual homes, we were critical of the lack of financial assistance, and/or significant delays in the provision of it, to large Roman Catholic homes when it was clear from inspectors' reports that the physical conditions in the homes required urgent improvement, and that too few over-worked and untrained religious staff were caring for large numbers of children. Although many of the children in these homes had been

132 SNB 100125.

admitted without any reference to or involvement of statutory authorities, they were still ultimately children of the state and their welfare was its responsibility. We are aware that particularly in the 1920s through to the 1960s many children were also living in poor physical conditions in their family homes, but the children in the voluntary homes did not have the advantage of parental and wider family care. Many of the witnesses we heard from told us they felt alone, scared and unloved.

Funding of training schools

195 One aspect of the voluntary care of children that attracted funding even in the 1920s was that provided in industrial schools and then training schools. The 1908 Children and Young Persons Act provided the Chief Secretary with powers to recommend that monies be paid from Treasury towards the expense of any child or youthful offender up to certain limits, and also legislated for local councils to provide for children's reception and maintenance in the schools. Industrial schools run by voluntary organisations could also receive children privately admitted to care. The funding of voluntary placements had to come from voluntary subscriptions and donations, to the body responsible for the school.

196 In January 1922 the Minister of Home Affairs established a Committee on Reformatory and Industrial Schools in Northern Ireland, which reported in June 1923. The Committee recognised that many schools were operating under extreme financial pressure because falling numbers meant overheads were high and that in some schools children were involved in trade activities rather than educational pursuits in order to raise funds. The Committee recommended that funding of homes should be by capitation grant of 2/6d per head, per week from the Government and an equal amount provided by local authorities.[133]

197 The MoHA reported to the Governor of Northern Ireland in 1927 that Government grants of 7/6d per week were being paid for each child in an industrial school and that county boroughs were required to make an average payment of 5/- per head, per week for children from their areas accommodated in the schools. The report also noted that while the amount of parental contributions for the year was just over £657 that contribution was:

133 SPT 17081-17109.

> "...a valuable method of impressing upon certain types of parents their responsibility for the maintenance of their children and is enforced in every case where this can be done without undue hardship".[134]

198 The 1950 CYPA set out the circumstances in which a child could be committed to a training school. The subsequent 1952 Training School Rules[135] set out how training schools should be managed and run. The responsibilities of the Board of Management of schools were set down and these included appointing a finance committee and exercising effective control over all expenditure.[136]

199 Article 150 of the Children and Young Persons Act (Northern Ireland) 1968[137] brought in new funding arrangements, confirming that funding for training schools was to be provided and controlled by central government. Grants which were to cover the full costs of maintaining a child in a training school, were administered by the MoHA and then in due course the NIO.

200 The DHSSPS and the NIO provided information about the financial relationship between the NIO and training schools. Schools were accountable to the NIO for the management of their expenditure and had to furnish the NIO with reports and accounts on request and comply with any directions by the NIO in respect of such records and accounts. They also had to submit quarterly and annual estimates of expenditure and maintain financial records enabling the school to monitor spending and plan their future operation. Also, although Boards of Management had responsibility for acquiring and releasing staff, staff could only be appointed after approval was obtained from the MoHA and then the NIO.

201 As will be clear from the chapters dealing with juvenile justice establishments, we found that on the whole from 1950 training schools were better funded than children's homes and, in particular, voluntary children's homes. The NIO closely monitored the schools and met regularly with representatives of the Boards of Management and senior staff. A clear benefit to the schools of this monitoring was that officials were alert to the financial needs of schools, for example to appoint new staff, improve and extend facilities, remedy damage to the fabric of a school, and generally responded to them in a sympathetic and prompt manner. Although there were examples of where shortages of staff affected the operation of schools we found

134 GOV 35008.
135 SPT 80063-80073.
136 SPT 80064.
137 SPT 80096-80110.

that access to funding was less contentious and more forthcoming. We concluded that was because training schools were meeting a statutory function that was intended in part to ensure community safety and provide public protection.

Funding of statutory residential childcare

202 When the Health and Social Services Boards were established on 1 October 1973, one of the responsibilities allocated to them was the administration of childcare services on behalf of the DHSS. While the DHSS retained responsibility for policy, strategic planning and resource allocation, the Boards were given responsibility for operational planning and provision of services.[138] A committees and advisory structure was developed for Area Boards, which included each Board having a Personal Social Services Committee which inter alia had responsibility for discharging the Board's statutory duties with regard to children and young persons.[139]

203 As we have outlined above, the level of funding available to each welfare authority, and then Board, and the amount it paid in placement fees to voluntary children's homes had a very significant impact on the level of funding available to those homes and, for example, the level of staffing they could afford. The same was obviously the case in relation to statutory children's homes, where the level of funding allocated to each home determined staffing levels and the training opportunities available to staff and the physical layout and maintenance of the home.

204 We heard evidence about three statutory children's homes, Kincora, a hostel for boys run by the EHSSB, and Fort James and Harberton House, children's homes run by the WHSSB. In relation to Kincora, we found that the staffing levels in the hostel were always below those recommended in the Castle Priory guidelines and that for the first six years it operated there was only one member of care staff. However, it was clear that once the post of assistant warden was created, subsequent occasions when the warden had to work alone were due to difficulties in recruiting an assistant warden rather than any lack of funding for that post. There was also evidence that resources were invested in improving the physical layout of the home, for example adding staff accommodation so that the warden who lived in could have more separate sleeping accommodation

138 FJH 20659.
139 FJH 20663.

and no longer had to share a bathroom with the boys. We received no complaints about the facilities provided to the boys and positive reports about the efforts to secure them work experience and employment.

205 The evidence we received about Fort James and Harberton House raised significant issues about how the WHSSB's lack of funding for its childcare services adversely affected the operation and staffing of these children's homes. This evidence also raised the more fundamental question of whether the WHSSB's lack of funding for childcare services was as a result of historic underfunding of the North West of the province by the Government. The evidence we received in the Governance and Finance module highlighted the complexities and tensions surrounding the allocation of core funding to the Boards. We decided that consideration of these general funding issues was relevant because of the context they created for the WHSSB's attempts to secure additional funding for its childcare services after peer sexual abuse was detected in Harberton House.

Allocation of core funding to Boards

206 The funding of the Boards was determined by the distribution of the Northern Ireland block grant received from Westminster. The Secretary of State for Northern Ireland had autonomy to determine the allocation across spending Departments, including the then DHSS. The bidding for resources by Departments and allocation of resources was managed by the Northern Ireland Department of Finance and Personnel.

207 The Boards were entirely dependent on the funding they received from the DHSS. Each Board's allocation in 1973 was made up of monies previously allocated to the bodies formerly responsible for the provision of health and social services within its area. Where an existing body or service's field of responsibility straddled the boundaries of Boards, an apportionment of funds was made on the basis of population and agreed with the Boards concerned.

208 When giving evidence in Module 5 of the Inquiry Dominic Burke, a former senior manager of the WHSSB, indicated that because the funding allocations to the Boards were based on the historical income of their predecessor County Council Welfare Committees, the WHSSB was at a funding disadvantage from the beginning. He explained:

> "The budgets in those days were -- the county councils received their money from the rates paid to them from businesses and domestic houses in the area. In areas like Belfast or County Down, County Antrim to some extent, the amount of rates raised was clearly greater there than it was in the west of the province and in and around County Londonderry, the city of Derry and Tyrone and Fermanagh. So there was an underlying discrepancy, as it were, or deficit with regard to the funding in the West, and while it moved forward, that underlying deficit wasn't addressed for a long time. From time to time it was, but not consistently."[140]

209 Tom Frawley held a number of senior positions in the WHSSB and was ultimately the General Manager of the Board. Mr Frawley provided a statement for Module 5 in which he set out the particular challenges faced by the WHSSB and the significant calls on the funding available to it. He explained that when the Boards were established in 1973, while the population of the Western area represented approximately 16% of the total population of Northern Ireland, 25% of the people who lived in the area were less than fourteen years of age and 10.5% were over 65 years of age. He pointed out that the population of the Western area was amongst the most disadvantaged in Northern Ireland:

> "....the area had the worst record in Northern Ireland for unfit dwellings and for overcrowding; had the most socially and economically deprived population in the Province; had one of the highest incidents of heart diseases in the world and one of the highest unemployment rates in the United Kingdom".[141]

210 He also pointed out that while at that time the average density for the Western area was 56 persons per square kilometre, it ranged from 29 persons per square kilometre in Fermanagh to 262 persons per square kilometre in Derry. He explained that this range meant the WHSSB had to respond to very different types of service need and faced a considerable challenge in ensuring that services were as accessible as possible.[142]

211 While we accepted Mr Frawley's analysis of the particular challenges facing the WHSSB, we recognised that other Boards were also having to handle the organisational and funding implications of reorganisation and

140 Day 125, p.32.
141 FJH 600.
142 FJH 599-600.

integration of health and social services. For example, Bob Bunting, a senior manager in the EHSSB, pointed out that reorganisation had created an imbalance in the size of Boards which left the EHSSB responsible for serving over 40% of the Northern Ireland population. He explained that this meant it had to be organised into six districts to ensure the effective delivery of services and that resources such as children's homes had to be shared and were no longer managed centrally. He also pointed out that the EHSSB's catchment area included Belfast with some of the most socially deprived inner-city areas in Europe, which was recognised during the 1970s when the EHSSB area was included in European Union initiatives to address social disadvantage in what were categorised as "Areas of Special Social need".[143] It was also the case that the EHSSB argued that the core funding it received did not take sufficient account of the costs it bore in providing specialist medical services for the whole of the province and medical training.

212 When the Boards were first established, the Personal Social Services (PSS) element of the budget was safeguarded by being separately earmarked in the annual allocations made to the Boards by the DHSS. This was in order to ensure that PSS resources were not diverted to address health needs. Each Board had a range of Programmes of Care such as Acute Care, Mental Health, Physical Disability and Family and Child Care, and had to decide how to allocate its grant across these Programmes of Care so that it could meet its statutory responsibilities and the related policy aims and objectives set by the DHSS.

213 Dominic Burke told us that funding for existing services, such as residential childcare services, took the 'lion's share' of available funding and that there was always a debate about how funding available for allocation to new initiatives might be shared between the different Programmes of Care.[144]

Proposals for the Allocation of Revenue Resources for Health and Social Services (PARR)

214 Following reports on resource allocation in England, Wales and Scotland the DHSS set up a Working Group, which included representatives from the four Boards, to determine a more equitable means of allocating available

143 RUB 5575.
144 Day 125, pp.42 to 43.

funding to Boards. The Working Group was asked to provide advice on the fairest way of sharing out the limited financial resources available rather than commenting on the level of funds needed. The report of the Working *Group Proposals for the Allocation of Revenue Resources for Health and Social Services (PARR)* was published in November 1978.[145]

215 The Working Group acknowledged that although in the years from 1973 some efforts had been made to channel growth money to priority areas and client groups, the general effect of the allocation system had been to perpetuate the historical situation, rather than to reflect any objective measure of the need for services of the population served. To address this situation it recommended the use of a funding formula based on the methodology of the English RAWP (Resource Allocation Working party) formula, which was used to calculate allocation of funding to Regional Health Authorities and on the Revenue Support Grant calculation used in England to calculate social services expenditure requirements for local authorities.

216 The aim was that the formula would enable the distribution of available resources on the basis of the relative needs of the populations served by each Board and also the additional specific costs incurred, in particular by the EHSSB, in providing regional services to patients from outside a Board's area.

217 The resulting funding formula was known as PARR (Proposals for the Allocation of Revenue Resources). PARR operated as follows:

(a) account was taken of the population of each Board's area;

(b) each service areas population was then weighted using factors such as age, sex, and utilisation rates;

(c) adjustments were then made to take account of factors which included mortality rates; incidence levels and rurality;

(d) all the weightings were then brought together in the same proportion as the historic revenue expenditure on each category to arrive at each Board's initial allocation;

(e) general practitioner service costs were excluded from the distribution system and continued to be funded on an actual cost basis; and,

(f) further adjustments were then made on the movement of patients across administrative boundaries (patients resident in one Board area

145 GOV 437-513.

receiving treatment in a hospital administered by another Board) and the additional costs of teaching and other regional responsibilities to arrive at each Board's notional share of revenue resources.

218 Although much of this work was informed by developments in the rest of the UK, the significant difference was that in Northern Ireland the allocation to the Boards included funds for PSS, while in the rest of the UK these remained the responsibility of local authorities.

219 The DHSSPS told us that the Working Group recognised that the social needs of the population were subject to many influences, including employment, income, housing, health and education. It explained that Standardised Mortality Rates (SMRs) were used as a measure of relative need in the Health element and they were also considered relevant for PSS on account of the Department of Health England's conclusions that:

> "On the whole, the evidence suggests that high SMRs are associated, not only with morbidity but also with poor social conditions".[146]

220 The Working Group recommended that it was no longer appropriate to protect the PSS budget in the way described above as it would create 'practical difficulties' in applying the formula and that a single integrated allocation for health and social services should be provided to each Board[147].

An initial allocation was determined for each Board on the basis of:

(a) the sum required for the maintenance of existing levels of services, updated for pay and price increases;

(b) Revenue Consequences of Capital Expenditure (RCCE);

(c) earmarked allocations; and,

(d) a minimum growth allocation to offset the effects of changes in the population structure.[148]

221 The proposed methodology was tested and notional allocations allocated to each Board using the PARR formula were provided in the report. The DHSSPS pointed out that there was very little difference between the actual allocations the Boards received in 1978-79 and the notional PARR allocations and that, in particular, the WHSSB's actual allocation was 0.1% more than the notional allocation calculated by the PARR formula.

146 GOV 443.
147 GOV 472.
148 GOV 553.

222 The report concluded that the use of the PARR formula would produce an equitable allocation amongst the Boards, but that a cautious approach should be taken to its implementation to avoid the potential for disruption of services to patients and clients.

Cautious approach to the implementation of PARR

223 John Hunter held senior posts in the DHSS in the period 1979 to 1996, culminating in his appointment as Chief Executive of the Management Executive for the Health and Personal Social Services in 1990. He confirmed that the recommended cautious approach to the introduction of PARR was adopted. He explained that the agreed policy was to adjust the Boards' historical allocations over time through the differential allocation of growth funds to reflect their relative needs, but avoid any disruption to the health and social services currently being provided.[149] This meant that the existing actual allocations to the Boards continued and were not affected by the PARR calculations. Mr Hunter explained that the speed of adjustment of the Boards' historic allocations to the outcome of the formula was dependent on the size of any additional resources available to the DHSS, together with the capacity of Boards themselves to redeploy resources through efficiency savings.

224 Mr Hunter recalled that all Boards expressed dissatisfaction about the allocation they received and complained about underfunding for service provision. He described these responses as "a perennial problem affecting the Health and Personal Social Services in Northern Ireland and elsewhere".[150] Dr McCoy also told us that all the Boards argued for more funding on an annual basis, and in a response to a question from Senior Counsel indicated that the WHSSB was not necessarily shouting louder or more frequently than the other Boards for funding.[151]

225 Mr Hunter recalled that the EHSSB considered it was under-resourced in regard to its provision of most regional medical services, and also that the WHSSB raised its relative underfunding, arguing that the PARR formula did not adequately take account of the higher levels of social disadvantage in the Western area, which resulted in higher levels of morbidity and social need.

149 GOV 628.
150 GOV 629.
151 Day 126 pp.121 to 122.

226 He told us that as far as he recalled the WHSSB Board never argued through its area and operational planning process that it was under-funded for a particular service. He explained that if the Board had done so he was confident:

> "the Department would have expected the Board to reallocate resources from within, given its responsibility for allocating its budget to best meet the needs of its local population. Had the Department intervened with additional money it would have undermined the Board's responsibility for service provision and management. This would have been contrary to the principle of subsidiarity on which the respective roles of the Department and Boards were based."[152]

227 The WHSSB clearly considered that its overall funding situation, as opposed to its funding for a particular service area, was deficient, and additional core funding from Government was necessary to address the problem. In its Strategic Plan for 1987 to 1992 it included the following as one of its ten major issues:

> "This Board's acknowledged underfunding position, which according to the PARR formulae amounts to almost £6.5 millions limits the scope for achieving cost improvement targets. To secure equity in the geographical distribution of resources continues to be a major issue for the Board."[153]

A Fair Share

228 In order to address this major issue, the WHSSB prepared and submitted a document entitled *A Fair Share*[154] to the DHSS in February 1987 and asked it to urgently review the method of resource allocation between the four Boards. It made the case that the WHSSB's underfunded revenue baseline resulted in very serious understaffing levels, across all of its Programmes of Care, in comparison with the other Boards. There were few references in the report to childcare, but it did highlight a shortfall of 25 field social workers as of 1 October 1986 compared with DHSS recommended guidelines of one social worker per 5000 of the population.[155] It contrasted its position in relation to numbers of social workers with the other Boards, and showed that while it was in deficit the EHSSB had 54

152 GOV 629.
153 FJH 1030.
154 GOV 327-398.
155 GOV 354.

more social workers than the recommended levels. Although pressures on residential childcare were not specifically mentioned, it was stated that the shortage of qualified social workers meant that services such as fostering, alternative care for disturbed children and boarding-out arrangements were underprovided. It was clear during our consideration of Fort James and Harberton House children's homes that the lack of availability of these wider childcare services adversely affected the operation of these homes.

Review of PARR

229 We saw no evidence of a response from the DHSS to the *Fair Share* report, but in response to growing criticisms of the PARR methodology, in particular that it did not take account of relative need in the Board areas, the DHSS initiated a review of the methodology in 1987. The Review Group comprised officers from the DHSS and each of the four Boards. It was asked to consider the operation of the PARR formula in terms of how well it measured the relative need for health and social care and also to reflect on related developments in Great Britain. The final report of the review group was published in February 1989.[156]

230 The Review Group carried out a comparison of the actual allocations to the Boards against notional PARR allocations. As referred to above, the initial PARR calculations for 1978-79 had produced a notional distribution of revenue resources that was not markedly different to the actual allocations at that time. The Review Group found that in the intervening years the actual allocations to Boards, which had continued to be made largely on an incremental basis with Boards receiving shares of growth money broadly pro rata to their existing allocations, had increasingly deviated from the notional PARR allocations. It found that the WHSSB and the NHSSB in particular were receiving less than their PARR allocations.

231 The Review Group concluded that these deviations were mainly due to population changes not being reflected in the actual allocations. It identified that while the EHSSB's share of the Northern Ireland population had shrunk from 43.9% in 1978 to 1979 to less than 41% in 1987 to 1988, and its PARR notional share had therefore reduced from 54.4% to 51.3%, its share of actual allocated revenue resources had only declined from 54.4% to 53.9%. The report also showed the disparity between the WHSSB's PARR notional allocation of £96.5m and its actual allocation of

156 GOV 5290-5316.

£87.5m. The Review Group commented that it was evident that even with some skewing of available growth in recent years towards the WHSSB, the gap between actual and notional allocations was unlikely to lessen.[157] While the report identified that the EHSSB had received more than its PARR allocation it also made clear that the EHSSB's view was that its regional responsibilities were not adequately reflected in the PARR formula.

232 It also recognised that a number of developments in the intervening period from 1978 had impacted on the PARR process, including that the resource climate had changed and the DHSS had more limited resources available to it. This meant that the original Working Group's expectations that equity of distribution of resources between the Boards could be achieved through differential allocation of growth funds and not redistribution of existing funds, (i.e. baseline cuts), could not be realised. Instead the DHSS was in the situation of trying both to ensure baseline services were adequately funded while keeping pace with demographic changes and medical advances.[158]

233 The Review Group was unable to reach agreement about how the discrepancies between the actual and PARR notional allocations should be addressed, or to resolve the more fundamental issue that the PARR formula served to reinforce existing spending patterns and was influenced by past spending decisions as well as need. To move things forward the DHSS proposed an approach of continued use of the PARR formula but on the basis that broad equalisation, as in moving each Board to its PARR notional funding level, would be pursued without reducing any individual Board's baseline in any year. In order to achieve equalisation on that basis the DHSS proposed that the allocation process should provide for:

(a) uprating of baselines by GDP [Gross Domestic Product] factors;

(b) the identification of earmarked sums for regional and national priorities; and

(c) the allocation of the balance between Boards deployed through operational plans.

234 However, the caveats attached to this approach, which were that the target for equalisation should be to get each Board receiving within plus or minus 2% of its PARR target, and that achieving that target without adjusting current allocations could take up to ten years, were not acceptable to the Boards. The Review Group acknowledged that the positions adopted by

157 GOV 544/5.
158 GOV 554.

the Boards would be unlikely to be resolved through further discussion. Therefore, the members formally noted that they had been unable to reach a consensus on the role of the PARR formula in the future and that this issue would remain to be resolved by the DHSS alone.[159]

235 While agreeing that a Social Deprivation Factor should be included in the PARR formula the Review Group could not identify what it should be and recommended that further work and possibly research should be carried out to determine it.[160] This further work was completed, but was unsuccessful because of a lack of consensus about what social deprivation factor should be used, and how it should interact with the Standardised Mortality Rates and PSS social elements which were already included in the formula.[161]

236 Despite these difficulties, as the DHSPPS pointed out to us, the Review Group concluded that the PARR formula, with identified refinements and amendments, remained a sound and valuable model for identifying the relative needs of the population of each Board. However, we noted that the Review Group added a qualifier that the implications of a new comprehensive planning system would have to be considered. We took this to refer to the new planning system heralded by the DHSS in 1980 in its circular *Planning and Monitoring of the Health and Personal Social Services*. This circular announced the DHSS's decision to introduce a new and comprehensive planning system that would incorporate both the Boards' views on their areas of need and priorities and the Department's responsibilities for regional policies and priorities. Boards were required, in accordance with DHSS regional policies, guidelines and priorities, to prepare five-year Area Strategic Plans and annual operational planning statements. Each Board was responsible for reviewing services within its area, assessing its needs and determining its priorities in order of importance and developing plans to meet its priorities. The Boards' five-year Area Strategic Plans were to be reviewed by the Department and extended every third year of the planning cycle.

237 Accountability Reviews were introduced in 1980 as a mechanism for reviewing Boards' progress in achieving targets set by Government in its regional strategy and agreed through the Board's own area and operational plans. Mr Hunter could not recall whether the Child Care

159 GOV 557.
160 GOV 548.
161 GOV 423.

Branch was specifically involved in reviewing progress on achieving the childcare objectives set by the DHSS.[162]

238 An Accountability Review of the WHSSB's 1989 Action Plan was held in June 1989 between Mr Elliott, Permanent Secretary of the DHSS, and Mr Frawley.[163] This was four months after the publication of the report of the review of PARR. The record of the review, which was produced by DHSS officials, included commendation for the Board's financial management and ability to meet cost improvement targets, but stressed that the measures to achieve this needed to be carefully monitored to ensure that "targets are achieved without any reduction overall in the level or quality of services available to patients and clients." There was no recorded mention of the Board's position that it was underfunded. While we appreciated that the purpose of the meeting was to review how the WHSSB was meeting its strategic and operational plans within available resources, the total lack of reference to the accepted underfunded position of the WHSSB in relation to its nominal PARR allowance suggested an unhelpful lack of connection between related processes. We considered that the Review Group's question of what the relationships should be between the comprehensive planning system, the PARR formula and resource allocation in general was a pertinent one, unfortunately it appears not to have been addressed.[164]

The position of child care services within integrated services

239 We also noted that apart from an agreement that the Board would review and report on the availability of a *Physiotherapy Service for Handicapped Children*[165] the only other specific comment recorded on childcare services in the Accountability Review was a reference that the Board would be able to benefit from access to funds reserved by the DHSS to improve child abuse training.[166] The recorded priorities, areas of pressure and of growth related to health services and adult social care. This suggested that, at this time at least, residential childcare was not the highest priority for the Board.

240 Two former officers in charge of Fort James shared their views that social services in general and childcare in particular struggled to get the priority

162 GOV 630-631.
163 GOV 622 -626.
164 GOV 553.
165 GOV 625.
166 GOV 624.

they required within integrated services. Dominic Burke disagreed with these views when they were put to him and he told us that priority was always given to meeting statutory responsibilities. While we accepted that may have been the case within the social services department we considered that, given the range of responsibilities the Board carried, there may have been times when the weight of the health agenda left less focus on the social services agenda. We asked Dr McCoy about this when he gave evidence and he commented:

> "I think it would be a reasonable statement to make that childcare was a bit of a Cinderella within the integrated services that we had so that was in itself a risk. It was a risk for childcare services and the funding of childcare services, yes."[167]

We concluded from this that the risks for the funding of childcare services were even greater within the context of a Board which was underfunded in relation to the agreed funding formula being used at that time.

A Second Review of PARR

241 The WHSSB's dissatisfaction with its actual allocation against its notional PARR allocation continued to grow, and was evident in the minutes of the Board meeting held in May 1991 which recorded the opening remarks of the Chairman of as follows:

> "..He said despite the Board's progress and achievements to date he still had one major continuing disappointment and that was the Board's underfunded situation. In spite of well reasoned arguments put forward by the Board and which in fact had been accepted by the Department, the issue had not been addressed to his satisfaction. He emphasised that the resolution of this issue will be a major priority over the next 12-18 months."[168]

242 In the face of continuing criticism of the PARR methodology, and particularly its ability to identify relative need, and following on from a review of the RAWP methodology in England, a further attempt to identify factors which would allow weightings to be allocated to different needs variables was made in 1994.

167 Day 126, p.147.
168 FJH 19367.

243 A Capitation Review Group was established, which included representatives from the Boards. In the report of its work[169] it recognised that to provide a fair and equitable means of allocating resources in response to the need for health and social care, a good formula should take account of the additional needs of certain disadvantaged sections of the population, for example those on low incomes, single parents and those from lower socio-economic groups.

244 The Capitation Review Group recommended that a new formula should be devised based on Programmes of Care rather than service areas to take account of the integration of health and social services and to align better with the DHSS strategic planning process. It proposed a new formula that applied relevant populations to each Programme of Care and weighted them by age/cost relationships, and in some areas adjusted by needs variables.

245 However, although it considered and allowed for the higher prevalence of morbidity amongst certain groups in the acute, elderly, maternity and mental health Programmes of Care, it concluded that it:

> "had to accept that it has no quantifiable evidence of the relationship between population characteristics (other than age and/or sex) and variations in intensity of care need."[170]

246 In relation to the Family and Child Care Programme of Care in particular it concluded:

> "There is no empirically available evidence which could be used to substantiate any particular weighting for any specific needs variable within this programme. Consequently the Review Group cannot make any recommendation in this area at this point in time."[171]

Once again it was identified that the actual allocation to the WHSSB fell below its PARR notional allocation, but the variance had reduced from the 1.5% variance found by the Review Group in 1989 to a 0.2% variance.

247 The final report of the Capitation Review Group was issued in September 1995. It reached agreement to recommend a capitation formula which was an aggregation of the estimate requirements for each Programme of Care, taking account of relevant populations weighted by age/cost relationships and/or needs variables. However, it had to conclude in relation to Family

169 FJH 21766-21814.
170 FJH 21806.
171 FJH 21788.

and Child Care that further work was needed to examine how service utilisation by age band is distributed throughout Northern Ireland[172] and to assess what impact if any, potential needs variables have on resource consumption.[173] Mr Hunter recalled that the WHSSB was unhappy with the outcome of the review and that after further representations from it a small adjustment was made to the outcome in the Board's favour.[174]

DHSSPS's views on whether the WHSSB was underfunded

248 In its written evidence the DHSSPS acknowledged the limitations of the PARR formula and the lack of success in identifying and agreeing social deprivation factors that could be applied in the formula to enable account to be taken of relative levels of deprivation. It pointed out that England experienced similar difficulties with its funding formula and that the uniqueness of Northern Ireland in respect of its integrated health and social services meant there was no GB modelling which could be used directly in the Northern Ireland context. Therefore, it suggested that PARR was as robust as possible given the availability and sophistication of data available to the DHSS from 1978 to 1995.

249 The DHSSPS also made the point that whilst PARR was a useful measurement tool it was never 100% accurate, therefore it should not be seen as the sole basis for measuring actual allocations during this period to determine if each Board received its 'fair' share of resources. However, presumably in acknowledgement that PARR was the only measurement tool used and therefore the one that Boards measured their allocations against, the DHSSPS addressed the issue of the WHSSB receiving less than its nominal PARR allocation.

250 It concluded that since the WHSSB was receiving slightly more than its PARR allocation in 1978, that meant that up to that point the WHSSB was not underfunded.[175] In their joint statement for the Governance and Finance module Tom Frawley and Dominic Burke specifically addressed this conclusion. They pointed out that the use of the PARR formula in 1978-79 "was not a conclusion rather it was a starting point"[176] and

172 GOV 572.
173 GOV 593.
174 GOV 630.
175 GOV 426.
176 GOV 721.

that the formula was reviewed, critiqued and refined with each iteration building on the preceding analysis. They pointed to the fact that the review of the formula in 1989 identified that a funding gap of £9 million had built up for the WHSSB as an illustration of this continuous refinement.[177]

251 We are also of the view that the limitations of the PARR formula were such that it would be wrong to make definitive conclusions on the basis of the initial use of the formula to make notional allocations. However, it is equally the case that given the continuing limitations with the formula the conclusions from the 1989 review also have to be treated with caution.

252 The DHSSPS accepted that over a period of time the WHSSB's actual allocations, like a number of other Boards, was less than the notional PARR allocation.[178] However, it told us that the DHSS constantly strove to ensure all Boards received their fair share of the limited funding available and that it was recognised in the report of the 1989 review of the PARR formula that "the Department pushed any available money towards the Western Board."[179] The DHSSPS pointed out that the DHSS's efforts to better align its allocations to the WHSSB resulted in the 1.5% deficit in the actual allocations to the WHSSB received in 1989, compared to its notional PARR allocation, being reduced to a 0.2% deficit by 1995.

253 The DHSSPS added that there was no indication from the WHSSB's Area Strategic Plans or Operational Plans that it was failing to discharge its statutory childcare duties as a consequence of the funding provided to it, or that it had to re-channel resources from non-statutory obligations to discharge its statutory childcare duties. While that may be the case, it is clear in response to the recommendations in the report of the review of co-ordinated peer sexual abuse in Harberton House that the WHSSB made specific requests to the DHSS for additional funding to strengthen its childcare services.

WHSSB seeking funding to improve its childcare services

254 At its meeting in February 1991 the WHSSB's Community Care Committee agreed that the Board's concerns about the need for additional funding for childcare should be communicated to the DHSS. Mr Frawley confirmed

177 GOV 720.
178 GOV 427.
179 GOV 425.

that he would:

> "...put forward the case again for the Board's uniquely underfunded situation and ask the Department to consider the matter in the knowledge of the analysis they have sight of and consider making some exceptional arrangement for the Board."[180]

255 Mr Frawley wrote to Mr Hunter setting out the Board's concerns and then met with civil servants to discuss the matter. A civil servant, Mr Green, produced a minute of the meeting in which he recorded that Mr Frawley made clear the Board's continued grievance about its funding deficit and that the DHSS was not doing enough to address it. He recorded that he explained to Mr Frawley that the funding allocations for 1991-92 had been discussed fully with the Boards and could not be unstitched, that there was no reserve held by the Department that could be used to increase the WHSSB's share and that in spite of the limited room to manoeuvre the DHSS had already skewed a further £300,000 to the WHSSB. He also assured Mr Frawley that the DHSS remained fully committed to moving towards a full capitation based funding position. Mr Frawley was not satisfied with these explanations and asked for a meeting with Mr Hunter.[181] This meeting duly took place on 6 March 1991, and Mr Hunter sent a memo to Mr Green about it in which he stated that he provided the same explanations to Mr Frawley as Mr Green had about why the WHSSB's funding allocation for 1991-92 could not be increased. He also explained to Mr Frawley that deliberations on 1992-93 funding allocations would take account of the WHSSB's target allocation and that the Board would be free to use any additional sum to develop childcare services in 1992-93. However, he stated that he made clear:

> "..it was the Board's responsibility to manage any problems which currently exist in respect of the delivery of these services."[182]

256 Mr Frawley subsequently wrote to Mr Hunter on 20 March 1991 to record the WHSSB's Resource Allocation Committee's displeasure at what it perceived as "positive discrimination by the Department against this Board in properly addressing the issue of equity in resource allocation". He went on to state that "Board members felt that their position and that of the Board in relation to both staff and children was becoming untenable".[183]

180 FJH 10437.
181 FJH 50740-507401.
182 G0V 35009.
183 FJH 50742-50743.

He concluded his letter:

> "I write this letter not in any way to challenge or threaten the authority of the Department. I merely feel it is essential at this point in a Financial year your Executive and also the Minister should be aware that the Board and its staff will not be able to contain the political dimensions of the failure to address an issue which has now been with us for nearly 20 years."[184]

257 Mr Frawley sent a second letter to Mr Hunter on the same day, in which he reported that the anger and frustration of the WHSSB's Resource Allocation Committee at the failure of the Department to address the PARR issue was particularly felt in relation to childcare "in light of our recent difficulties".[185] He went on to contrast the WHSSB's position with that of the EHSSB, pointing out the number of assessment units and residential childcare facilities available in Belfast. He concluded the letter by putting on record to the Executive the Committee's "deep dismay at the failure to recognise our deficiencies in child care staffing which we believe are directly related to the historically [sic] underfunding of the Board."[186]

258 Just prior to this correspondence Dominic Burke wrote to the Chief Social Work Inspector, Dr McCoy, to make what was to prove an unsuccessful bid for additional funding of £130,000 to develop an assessment and treatment unit at Harberton House. Mr Burke made clear in his letter that the WHSSB was still experiencing sustained pressure within its childcare services.[187]

259 Mr Hunter's view that it was up to the WHSSB to reprioritise the allocation of its funding if it was experiencing pressure in a particular area was reiterated by the DHSSPS in its written evidence to us. When Dr Harrison, representing the DHSSPS, was asked to comment on HSCB's position that the WHSSB was underfunded she responded that all Boards argued that they did not get sufficient money. She pointed out that the comparisons in the Bunting report between the staffing levels in North and West Belfast in comparison to the Foyle Unit of Management[188] were based on allocated funding rather than the overall level of funding provided to the respective Boards, i.e. it was for the WHSSB to decide how to prioritise its funding

184 FJH 50743.
185 FJH 50744.
186 FJH 50744.
187 FJH 588.
188 FJH 20301.

and how much money to spend on its children's services and social work services.

260 Whilst we accept that it was the responsibility of the WHSSB to manage its resources to best effect in order to meet its statutory responsibilities, we considered that it argued well in the *Fair Share* report that it was pressed across all of its Programmes of Care and had very limited ability to reprioritise and reallocate funding.

DHSS's attempts to adjust actual allocations

261 However, we also considered that the DHSS was in a similar position in that it had limited growth money to use to adjust actual allocations and it experienced considerable resistance when it attempted to redistribute funding from one Board to another. For example, when the DHSS informed the EHSSB in August 1988 that circa £240,000 of funding previously allocated to it was going to be redistributed to the other Boards, it resisted strongly and made the matter politically sensitive by stating that the reduction would mean it could not honour agreements it had reached with the providers of voluntary children's homes, or make planned improvements to its own residential child services.[189] The EHSSB informed the providers of voluntary children's homes about the planned reduction in funding and the implications for them and they in turn wrote to the DHSS to make clear the impact any reduction in funding would have on their services.[190]

262 The same difficulties arose when the DHSS tried to redistribute core funding from the EHSSB to the other Boards as part of implementing a move towards full capitation funding. There was a cross boundary adjustment made in the financial year 1992-93 where funds were taken from the EHSSB and reallocated to the other Boards. This adjustment meant that the WHSSB received recurring additional funding of £3million in its baseline budget. However, in a letter of September 1992 to Mr Frawley, Mr Hunter expressed the DHSS Management Executive's concern about the speed of the move towards full capitation funding.[191] The move towards this new funding regime had been part of the assurances that Mr Hunter and Mr Green had given to Mr Frawley when they met with him in spring of 1991 to explain why the WHSSB's request for additional funding to address childcare concerns could not be met.

189 HIA 5384-5386.
190 HIA 5377.
191 GOV 732.

263 Mr Hunter explained in his letter to Mr Frawley that the Minister had asked the Chairman of the EHSSB to undertake an assessment of the implications of moving towards full capitation funding over a three-year period, through the redistribution of resources. It was estimated that this would entail a baseline reduction of around £7 million each year for the EHSSB, which would then be redistributed to the other three Boards. Mr Hunter asked for an indication of how the WHSSB would deploy additional resources of £2 million to £3 million each year. He finished his letter by stressing the importance of this forecasting exercise to be completed with the strictest confidentiality until the DHSS was in the position to make a clear statement about the way forward.

264 It was clear from the resource allocation letters for the financial year 1993-94 that were sent to the Boards that this redistribution of funding did not occur, presumably because of successful representations by the EHSSB. The allocation letter sent to the EHSSB made no mention of a reduction in its core funding, but rather confirmed that its revenue allocation would be increased by £469,000. Although the WHSSB was also allocated increases of £342,000 in its revenue budget and £275,000 in its capital allowance, in total that was only £208,000 more of an increase than the EHSSB received and no way near the potential £2 million to £3 million increase indicated in Mr Hunter's letter to Mr Frawley. The DoH pointed out in its response to the Warning Letter process that in the financial year 1995-96 a further £4.5 million was taken from the EHSSB and redistributed to other Boards and this resulted in the WHSSB receiving an additional recurring £1.5 million in its baseline budget. The DoH accepted that it may be that representations by the EHSSB delayed and reduced the proposed reduction referred to in Mr Hunter's letter but pointed out that achieving the reallocation of funds in 1995-96 was a substantial result.

265 We noted that these tensions were not limited to core funding of Boards. They were also experienced in relation to the allocation of additional funding for work in relation to child abuse. In August 1993 the DHSS sent supplementary letters to the Boards about funding for 1993-94 in which it stated that it had found it impossible to agree a formula for distribution of funding of child abuse monies that would reflect relative need. The letter to the WHSSB stated that it would receive an additional £144,000 for this work but explained that in respect of recurring "funding for child abuse" it has not been possible to achieve a method for allocation which would be sufficiently robust and defensible and which would command respect by all the Boards, despite the involvement of the Assistant Directors from the

Boards working with officials to achieve a more refined formula.[192] In the absence of a more refined formula that could reflect relative deprivation, the DHSS decided to base the allocations on distribution of the child population aged 0-17 years in each of the Board areas, which was the same approach that had been used for the 1992-93 allocation.[193]

266 Paul Cummings, Director of Finance for the HSCB, told us that it took until the financial year 1995-96 for resources from the EHSSB to be redistributed to the other Boards. He explained that at that time the main driver for resource allocation was population size, therefore the NHSSB as the second of the most populous of the four Board areas received the highest uplift.[194]

Competing interests of Boards

267 Mr Frawley and Mr Burke commented to us in relation to redistribution of funding between Boards:

> "It appears to us, however the Department was unwilling to make the difficult choices involved in achieving equity...We would contend that there was little discretion ever exercised by the Department to re-allocate funds."[195]

268 While we understand this view, and have some sympathy with it, there is no doubt that the DHSS was hampered by limited funds for growth, a funding bias towards the protection of existing services and its inability to reach agreement with the Boards about a more equitable means of distributing funding on the basis of relative need. The PARR formula clearly had its limitations, but even a more sophisticated formula, able to take account of relative need, would have had limited success if the starting point continued to be the maintenance of existing levels of service.

269 Given that starting point, we understood the difficulties the DHSS faced in trying to cut funding to the EHSSB. The EHSSB was providing a wide range of health and social services in a deprived inner city area to a community dealing with the serious social unrest caused by the Troubles. It was also strongly arguing that the PARR formula did not adequately take account of its regional medical services and medical training.

192 SPT 80425.
193 SPT 80425-80426.
194 GOV 750.
195 GOV 724.

270 Balancing the competing interests of Boards, given the challenging circumstances they were all dealing with, would have made appearing to favour one Board at the expense of another complicated and unappealing, particularly given the political response at local level such shifts would have been sure to prompt. We noted that even now in retrospect, when commenting on the situation, the HSCB balanced the views of the WHSSB and the EHSSB. In its closing written submission to Module 5, the HSCB stated its position that while the WHSSB received a percentage of the available resources for growth from 1973 to 1975, that percentage was never sufficiently weighted in its favour to achieve a narrowing of the gap between its actual allocation and the sum that would have reflected its demographic profile, its levels of deprivation and the levels of health and social care need it was being required to respond to.[196] However, it also stated in its submission for Module 14, Governance and Finance, that the EHSSB had a valid argument at the time that it required recompense for factors such as regional medical services and cross-boundary flows for acute hospital treatment, and that this should be reflected in the allocation of resources by the Department.[197] Therefore, now as then, the competing interests of both Boards are acknowledged.

271 In the absence of the type of reallocation of funding that was required, it appeared that the PARR formula actually added to the frustration of the WHSSB; PARR provided recognition that it was underfunded but the status quo was largely maintained and the recognition did not translate into the additional funding at the level required.

272 While we recognised and accepted the difficulties the DHSS faced in reallocating core funding, we considered that it should have engaged more with the WHSSB about the practical and financial implications of implementing the recommendations of the Bunting Review into the circumstances surrounding the peer sexual abuse in Harberton House. As we have explained in greater detail in Chapter 23, Dr McCoy told us in a written statement that he thought the WHSSB's focus on resources when it was drawing up the Terms of Reference for what was to become the Bunting review was opportunistic.[198] When he gave evidence in person he confirmed that continued to be his view. We agreed with Dr McCoy that the focus in the Bunting review should have been on the circumstances

196 FJH 40912.
197 GOV 642.
198 FJH 40886.

and factors that enabled the peer sexual abuse to go on for so long undetected. However, lack of resources was a very relevant matter and the Bunting report assessed the WHSSB's childcare services in general, and its residential services in particular, to be under so much pressure that there continued to be risks for the children depending on them and the staff providing them.

Bidding for additional funds

273 Given that a radical redistribution of core funding was not found possible, the other means open to the DHSS to redress the balance was to bid for additional funds to address priority issues. Dr Hilary Harrison explained in her written evidence for Module 5 that the DHSS and its predecessors traditionally made bids for additional funding from the block grant in advance of the financial year, or as part of the in-year monitoring round, to address priority issues. She explained:

> "Funding so obtained was then allocated to Boards in a proportionate way or in a manner aimed at addressing specific or regional needs."[199]

274 It seemed reasonable to assume that in order to make decisions about allocating funds on a priority basis the DHSS would have to know how the Boards had allocated funding to Programmes of Care and in particular to meeting the Strategic Objectives it set for these Programmes. However, when he gave evidence in person Dr McCoy explained that that it was difficult for the Department to ascertain how the Boards actually spent their funding:

> "...we wouldn't have had good information about when they received their block grant, how it was allocated between Health Services and Personal Social Services, and even within that within the various programmes of care within Social Services, whether it be child care mental health or whatever."[200]

275 Dr Harrison explained in her oral evidence in this Module that although Boards were expected to provide financial returns known as FR22s to the DHSS it was not straightforward to compare and contrast expenditure, as the Boards accounted for their spend under different headings and it was difficult to disentangle, for example, the amounts each Board spent on fostering. Dr Harrison explained that around 1993-94 the Department

199 FJH 40388-40389.
200 Day 126, p.137.

improved the guidance about how the FR22 forms should be completed and held meetings with the Boards about their completion in order to obtain clearer, and therefore more comparable, information about expenditure to inform planning for the Children Order.[201]

276 This evidence suggested to us that monitoring arrangements that should have provided the Department with information to analyse and compare and contrast each Board's spend on family and childcare services and explore the relationship between expenditure and quality of services were not adequate up until at least 1993-94.

Reports about the impact of lack of resources on services

277 As indicated above, the evidence from former DHSS and SSI officials was that all Boards argued for more funding. Even within that context we would have expected that matters coming to the attention of inspectors about how resource difficulties were affecting a Board's ability to meet its statutory childcare duties would have triggered a significant response. Marian Reynolds, a SSI inspector, received such a report when she met with senior WHSSB childcare managers in April 1995.

278 Ms Reynolds subsequently wrote to C F Stewart of the DHSS, to report that these managers had informed her that the level of funding was such that at times decisions had to be made:

> "relating to discharge of statutory duties and/or compliance with procedural guidance".[202]

Ms Reynolds suggested to Mr Stewart that this might indicate the need for an assessment of the adequacy of funding to the WHSSB's Family and Child Care Programme of Care. Mr Stewart's response to the memo was to reassure Ms Reynolds that the allocation of funding was equitable, and that other Trusts and Boards were funded in a similar way, and that it was up to the Board to decide how to allocate money to childcare services.[203] Ms Reynolds told us that on the basis of this advice from Mr Stewart she considered there was no need to take further action. In response to questions about this matter, Ms Reynolds stressed that if a Board was saying it could not meet or was at risk of not meeting its statutory

201 Day 129, p.19.
202 FJH 40372.
203 Day 128, p.49.

functions it was for the Board to reallocate funding to ensure that the statutory functions it was responsible for providing were delivered.

279 In its closing submission to Module 5, the HSCB questioned this approach and suggested that on the basis of Ms Reynolds's report of the concerns expressed by the WHSSB managers the DHSS should have undertaken an "accountability review at a high level". The HSCB observed that this lack of action by the DHSS was in the context of the findings of a review into the death of a child in the care of the WHSSB, the review of peer sexual abuse in Harberton House, and the "'*mantra*' down the years about being underfunded in the West", all of which were known by the Department.[204]

280 While an accountability review may not have been necessary we consider that further engagement with the WHSSB childcare managers about the pressures they were under and how they might be managed was necessary. We accept that it was for the Board to manage its resources. Nevertheless, senior managers telling a member of the inspectorate that they were struggling to meet statutory childcare responsibilities merited a more considered and proactive response and we are critical of the DHSS's complacent response to this serious matter.

281 The DoH responded to this criticism through the Warning Letter process. It told us that Ms Reynolds had confirmed to the best of her recollection, that after her exchange with Mr Stewart, she met with senior WHSSB managers specifically to discuss the discharge of statutory functions, to provide advice and to seek assurance that the Board was continuing to discharge these functions in accordance with the requirements. It also stated that Dr McCoy had confirmed that such an approach would have been his standard practice in the light of such concerns and he had no reason to doubt the accuracy of Miss Reynolds' recollection. In addition, the DoH stated that Dr McCoy confirmed that he met with Mr Burke on at least a monthly basis and that, far from being one of inactivity or complacence, the SSI's relationship with the WHSSB was much closer than that which existed with any of the three other Boards and contact was on a more frequent basis. It is not possible for us to reach a conclusion on this additional evidence at this stage since we do not have the opportunity to question it and the HSCB has not had the opportunity to comment on it. However, we decided that since it provided such a different perspective about an important matter that it was appropriate to note it.

204 FJH 40930.

Conclusions about the funding of the WHSSB

282 Mr Frawley and Mr Burke noted Mr Hunter's statement that it was for a Board to reallocate funding if a particular service was under pressure and if the DHSS had intervened in such circumstances it would have been contrary to the principle of subsidiarity on which the respective roles of the DHSS and the Boards were based.[205] They commented:

> "An alternative view might be that 280k people living in the WHSSB were not being provided with a level of service equivalent to that available to people living in the rest of Northern Ireland, this situation having persisted over an extended period of time. This was a circumstance that surely warranted an intervention by the Department as the principal Authority within the Northern Ireland Health and Social Care system."

283 We concluded that the WHSSB was historically underfunded, that this was known by the DHSS, and that the adverse implications this funding shortage had on the provision of the WHSSB's childcare services was also known to the DHSS. However, we accepted why the commitment to protecting funding for existing services, the lack of growth funding and the understandable unwillingness of the Boards to accept any reduction in their funding, meant that the DHSS did not implement the PARR formula. Given the social unrest at the time, the pressures on all Boards, and the EHSSB's argument that it was being insufficiently funded for providing province-wide specialist medical care, we understood why the DHSS decided to maintain historical funding allocations for so long. We also recognised that eventually the DHSS did make cross-boundary adjustments in the allocation of funding to the Boards which resulted in the WHSSB receiving additional recurrent base line funding.

284 However, we were critical of the DHSS's failure to fully engage with the WHSSB about the specific resource difficulties which the Bunting report detailed it was facing in meeting its statutory childcare responsibilities. The DHSS accepted at that time that the WHSSB was receiving less funding than its PARR notional allocation and Mr Frawley made very clear to Mr Hunter the Board's view that historic underfunding was adversely affecting its provision of childcare services. We understood why the immediate allocation of additional funding was not possible; however, we considered the DHSS, or the SSI on its behalf, should have engaged more formally with the WHSSB to ensure it was taking whatever action was necessary

205 GOV 629.

to secure its childcare services. We were also critical that the DHSS did not respond appropriately to a report from an SSI inspector that senior WHSSB managers had informed her that they were struggling to meet statutory childcare responsibilities. We noted that through the Warning Letter process the DoH informed us that Ms Reynolds recalled that she did follow up these matters with WHSSB managers. We recognised the appropriateness of the DHSS preserving the boundaries between its roles and responsibilities and those of the Boards. However, it was the case according to the DHSS circular *Monitoring of Residential Child Care Services* issued in October 1983 that the Boards were accountable to the DHSS for the way in which they discharged their responsibilities in terms of the quality, range and availability of childcare services.[206] We therefore considered a more proactive response by the DHSS and/or the SSI on its behalf would have been appropriate to ensure that the WHSSB was effectively addressing the serious difficulties it was experiencing in the provision of its childcare services.

206 KIN 75357.

Appendix 1: The Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland) 1952

HIA 287

which the child has attended, or, if the child has not attended a school, from the last teacher of the child ;

(*d*) a certificate in such form as the local education authority may require from the school medical officer of the health authority for the area in which the parent of the child resides to the effect that the child may, in his opinion, be employed in the manner proposed without prejudice to his or her physical development and that the employment will not, in his opinion, render the child unfit to obtain proper benefit from his or her education.

4.—(1) A licence for the purpose of these Regulations shall be in a form approved by the Ministry and shall specify the name of the person to whom the licence is granted, the name of the child to be employed, the period of employment and such reasonable restrictions and conditions as to the employment of the child as the authority considers desirable ;

(2) a local education authority shall not grant a licence for a period in excess of six months.

5. The holder of a licence shall, at least seven days before the child takes part in any entertainment, notify the local education authority within whose area the entertainment is to take place of the forthcoming employment of the child and where the licence was not granted by that local education authority shall present the licence to that local education authority for inspection.

Sealed with the Official Seal of the Ministry of Education for Northern Ireland this 6th day of November, 1952, in the presence of

(L.S.) *R. S. Brownell,*
Secretary.

Voluntary Homes

REGULATIONS, DATED 25TH JULY, 1952, MADE BY THE MINISTRY OF HOME AFFAIRS UNDER SUB-SECTION (1) OF SECTION 101 OF THE CHILDREN AND YOUNG PERSONS ACT (NORTHERN IRELAND), 1950.

1952. No. 131

The Ministry of Home Affairs, in pursuance of the powers conferred upon it by sub-section (1) of Section 101 of the Children and Young Persons Act (Northern Ireland), 1950, and of all other powers enabling it in that behalf, hereby makes the following Regulations :—

1. These Regulations may be cited as the Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland), 1952.

2. These Regulations shall come into force on 1st October, 1952.

3.—(1) In these Regulations the following expressions have the meanings hereby respectively assigned to them, that is to say :—

"the Act" means the Children and Young Persons Act (Northern Ireland), 1950 ;

"administering authority" means the person or persons carrying on the voluntary home ;

"child" means a person under the age of eighteen ;

"Fire Service" means in the area of the County Borough of Belfast the Belfast Fire Brigade and elsewhere in Northern Ireland the Northern Ireland Fire Authority ;

"home" means a voluntary home as defined by Section 98 of the Act ;

"primary school" has the same meaning as in the Education Act (Northern Ireland), 1947 ;

"the Ministry" means the Ministry of Home Affairs for Northern Ireland ;

"training school" has the same meaning as in the Act.

(2) The Interpretation Act, 1889, shall apply to the interpretation of these Regulations as it applies to the interpretation of an Act of the Parliament of Northern Ireland.

4.—(1) The administering authority shall ensure that each home in its charge is conducted in such a manner and on such principles as will further the well-being of the children in the home.

(2) The administering authority shall make arrangements for the home to be visited at least once in every month by a person who shall satisfy himself whether the home is conducted in the interests of the well-being of the children, and shall report to the administering authority upon his visit and shall enter in the record book referred to in the Schedule hereto his name and the date of his visit.

5.—(1) The administering authority shall appoint a person to be in charge of the home :—

Provided that any person in charge of the home immediately before these Regulations come into force shall be deemed to have been appointed to be in charge of the home under this paragraph.

(2) The person in charge of the home shall compile the records referred to in the Schedule to these Regulations and shall keep them at all times available for inspection by any inspector appointed by the Ministry.

(3) The person in charge of the home shall be responsible for the custody of the medical records of each child and shall keep them at all times available to the medical officer or to any inspector appointed by the Ministry.

D

6. The administering authority shall secure that so far as is practicable each child in the home attends such religious services and receives such religious instruction as are appropriate to the religious persuasion to which he belongs.

7.—(1) The administering authority shall appoint a medical officer for each home in its charge.

(2) The duties of the medical officer shall include —

(i) the general supervision of the health of the children (excluding their dental health) ;

(ii) the general supervision of the hygienic condition of the premises ;

(iii) attendance at the home at regular intervals with sufficient frequency to ensure that he is closely acquainted with the health of the children ;

(iv) the examination of the children at regular intervals ;

(v) the provision of such medical attention as may be necessary, other than dental treatment ;

(vi) the giving of advice to the person in charge of the home on matters affecting the health of any of the children or the hygienic condition of the premises ;

(vii) the supervision of the compilation of a medical record for each child in the home containing particulars of the medical history of the child before admission, so far as it is known, of his physical and mental condition on admission, of his medical history while accommodated in the home and of his condition on discharge from the home.

(3) Notwithstanding anything in the preceding provisions of this Regulation, the administering authority may appoint more than one medical officer and may divide the preceding duties among them as it sees fit.

8. The administering authority shall make suitable arrangements for the dental care of the children in the home.

9.—(1) The administering authority shall notify the Ministry forthwith —

(i) of the death of any child in the home and of the relevant circumstances ;

(ii) of any accident in the home resulting in serious injury to a child or a member of the staff ;

(iii) if known to the administering authority, of the death of any child who dies within two months of ceasing to be in the home and of the relevant circumstances so far as they can by reasonable enquiry be ascertained ;

(iv) of any outbreak among the children in the home under five years of age of infective gastro-enteritis, and of any

outbreak of infectious disease among any of the children which the medical officer regards as sufficiently serious to be so notified.

(2) Where a child dies in the home or contracts an illness or sustains an accident which the medical officer considers to be serious, the administering authority shall notify the circumstances forthwith to the parent or guardian of the child, and, if the child were placed in the home by a welfare authority, to that welfare authority.

10.—(1) The administering authority shall obtain the advice of the Fire Service before opening a new home or making any structural alterations to an existing home, and shall arrange for the periodic inspection of each home in its charge by the Fire Service.

(2) The administering authority shall ensure that periodic fire drills and practice are carried out in each home in its charge, so that the staff, and so far as possible the children, are well versed in the procedure for saving life in case of fire.

(3) The administering authority shall report to the Ministry forthwith any outbreaks of fire in any home in its charge.

11.—(1) The person in charge of a home shall ensure that generally order is maintained by his personal influence and understanding and that of his staff, and resort to corporal punishment shall be avoided as far as possible.

(2) Where correction is needed for minor acts of misbehaviour, the punishment shall take the form of forfeiture of rewards or privileges (including pocket money) or temporary loss of recreation; provided that a light tap of the hand may occasionally be applied to the hand of a child with the object of indicating urgent disapproval rather than that of inflicting pain.

(3) Other forms of corporal punishment shall be subject to the following conditions:—

(*a*) It shall be inflicted only on the hands or posterior with a light cane and shall not exceed six strokes in the case of a child over 10 years of age, and 2 strokes in the case of a child over 8 and under 10 years of age. No child under 8 years of age shall be so punished.

(*b*) It shall not be administered by any person other than the person in charge of the home or in his absence his duly authorised deputy.

(*c*) A second member of staff shall invariably be present to witness the proceedings.

(*d*) No caning shall be administered in the presence of another child.

(*e*) Any child known to have a physical or mental disability shall not be subjected to corporal punishment without the sanction of the medical officer.

(4) Particulars of the administration of corporal punishment under paragraph (3) of this Regulation (giving the name and age of the child concerned, the offence and the number of strokes of the cane awarded him) shall be entered in the record book referred to in the Schedule to these Regulations.

(5) At the commencement of each quarter the administering authority shall furnish to the Ministry a return giving particulars of corporal punishment imposed during the preceding three months.

12.—(1) The Ministry may give directions limiting the number of children who may at any one time be accommodated in the home.

(2) The Ministry may give directions limiting the period during which any child may be accommodated in a home.

(3) The Ministry may direct any child to be removed from a home and to be placed in another home or in a welfare authority home or to be boarded out, or to be otherwise dealt with.

(4) The Ministry may require the administering authority to furnish returns of the children in a home or boarded out from the home in such form as the Ministry may from time to time direct.

13. The Ministry may give directions to the administering authority prohibiting the provision for the children in any home in its charge of clothing specified in the directions.

14. The administering authority shall furnish to the Ministry on demand such information as the Ministry may from time to time require as to the facilities provided for the parents or guardians or relatives of children in the home to visit and communicate with the children, and shall comply with any directions given by the Ministry as to the provision of such facilities.

15. The administering authority shall forthwith give notice to the Ministry when a person in charge of a home ceases to be in charge of that home, and of any new appointment to the position.

16. Where a primary school or a training school is established or maintained within a home, these Regulations shall not apply to any child during that part of the day in which he is attending the primary school or to any child who has been committed to the training school.

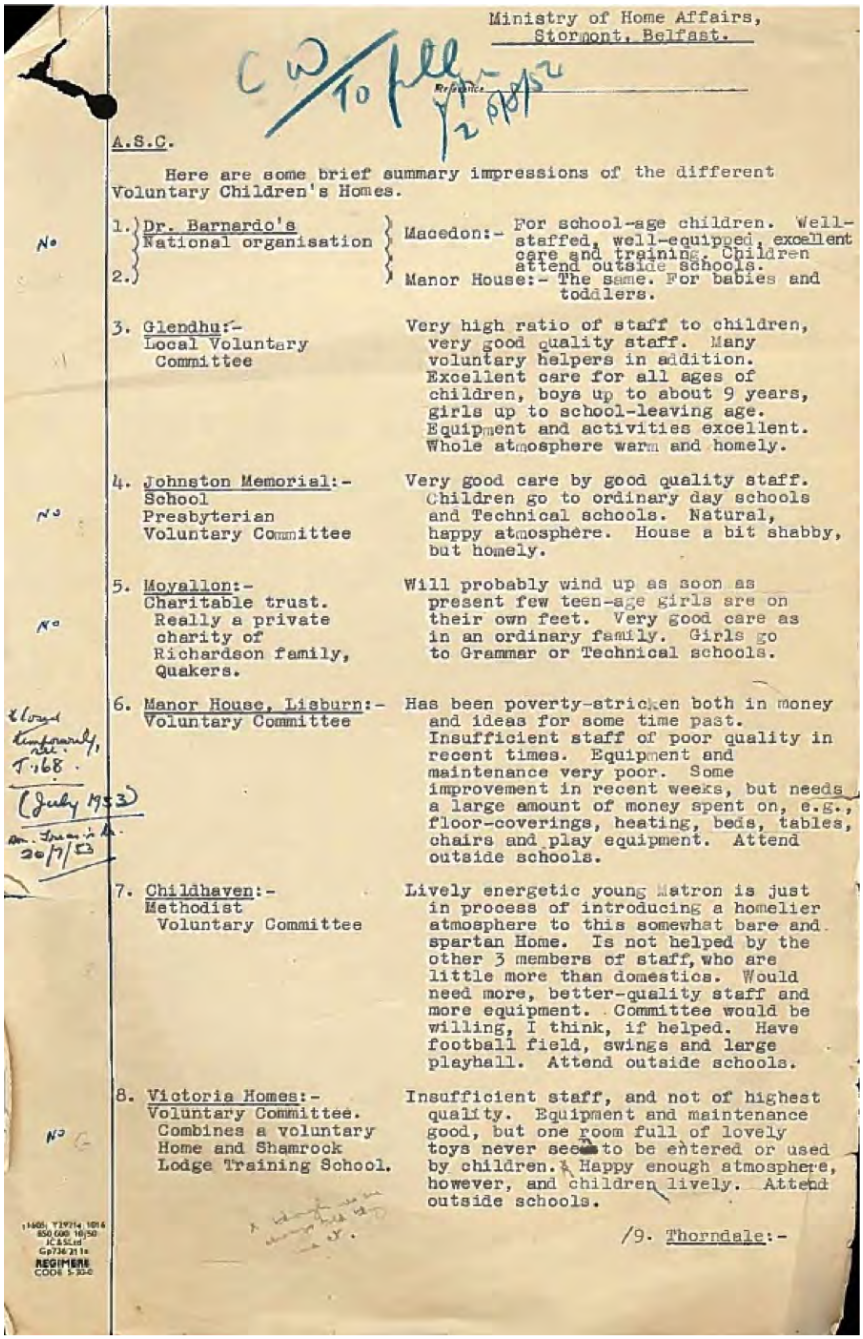
17. Where in the opinion of the administering authority it is desirable in the special circumstances of any situation that the provisions of one or more of the foregoing Regulations should not apply, a special arrangement may be made with the prior consent of the Ministry.

Sealed with the Official Seal of the Ministry of Home Affairs for Northern Ireland this twenty-fifth day of July Nineteen Hundred and Fifty-two in the presence of

(L.S.) (Sgd.) *J. B. O'Neill,*
Assistant Secretary.

Appendix 2: Miss Kathleen Forrest's Memorandum, Ministry of Home Affairs, 28 April 1953

HIA 1462



Ministry of Home Affairs,
Stormont, Belfast.

Reference

A.S.C.

Here are some brief summary impressions of the different Voluntary Children's Homes.

1.) Dr. Barnardo's National organisation — Macedon:- For school-age children. Well-staffed, well-equipped, excellent care and training. Children attend outside schools.

2.) Manor House:- The same. For babies and toddlers.

3. Glendhu:- Local Voluntary Committee — Very high ratio of staff to children, very good quality staff. Many voluntary helpers in addition. Excellent care for all ages of children, boys up to about 9 years, girls up to school-leaving age. Equipment and activities excellent. Whole atmosphere warm and homely.

4. Johnston Memorial:- School Presbyterian Voluntary Committee — Very good care by good quality staff. Children go to ordinary day schools and Technical schools. Natural, happy atmosphere. House a bit shabby, but homely.

5. Moyallon:- Charitable trust. Really a private charity of Richardson family, Quakers. — Will probably wind up as soon as present few teen-age girls are on their own feet. Very good care as in an ordinary family. Girls go to Grammar or Technical schools.

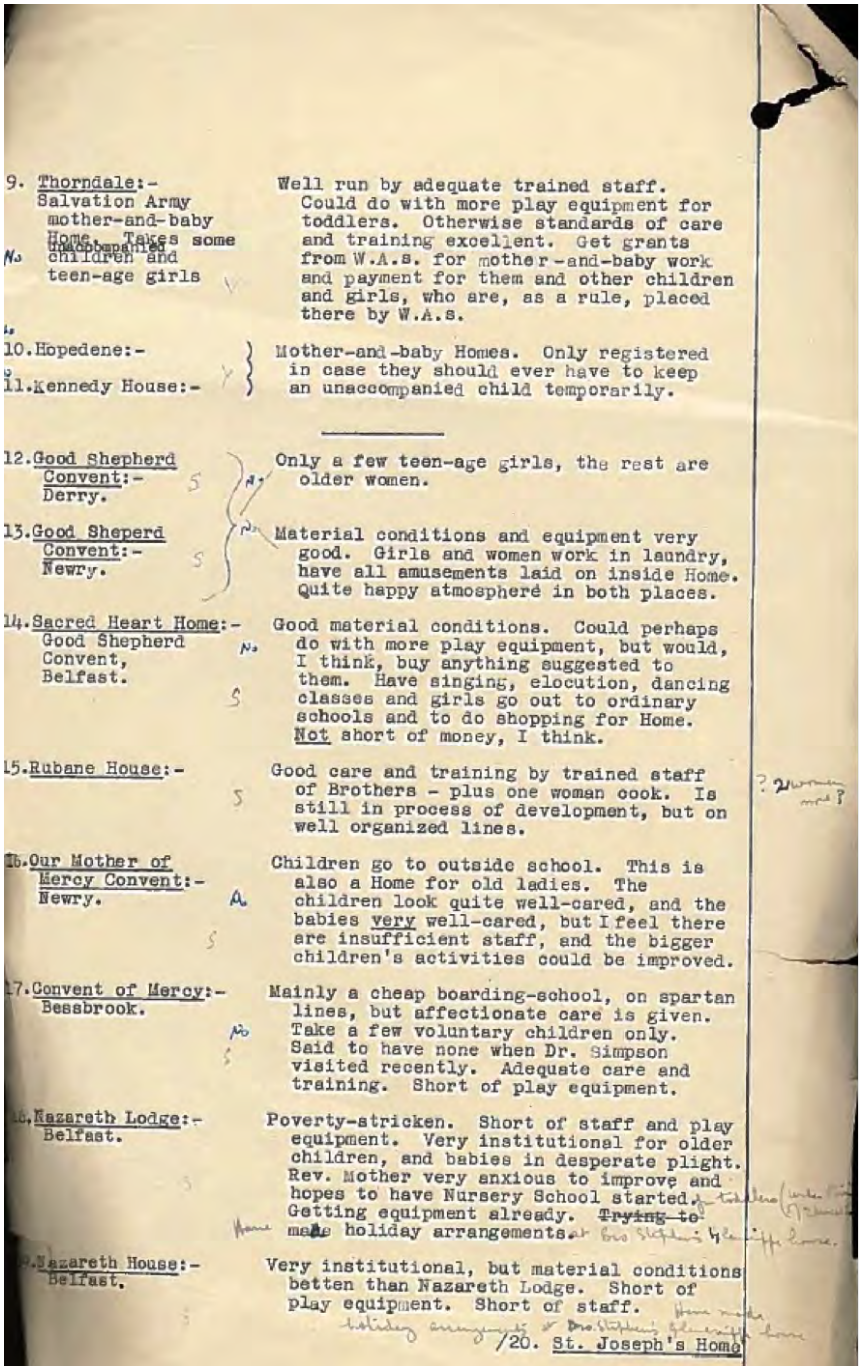
6. Manor House, Lisburn:- Voluntary Committee — Has been poverty-stricken both in money and ideas for some time past. Insufficient staff of poor quality in recent times. Equipment and maintenance very poor. Some improvement in recent weeks, but needs a large amount of money spent on, e.g., floor-coverings, heating, beds, tables, chairs and play equipment. Attend outside schools.

7. Childhaven:- Methodist Voluntary Committee — Lively energetic young Matron is just in process of introducing a homelier atmosphere to this somewhat bare and spartan Home. Is not helped by the other 3 members of staff, who are little more than domestics. Would need more, better-quality staff and more equipment. Committee would be willing, I think, if helped. Have football field, swings and large playhall. Attend outside schools.

8. Victoria Homes:- Voluntary Committee. Combines a voluntary Home and Shamrock Lodge Training School. — Insufficient staff, and not of highest quality. Equipment and maintenance good, but one room full of lovely toys never seem to be entered or used by children. Happy enough atmosphere, however, and children lively. Attend outside schools.

/9. Thorndale:-

HIA 1463



9. Thorndale:- Salvation Army mother-and-baby Home. Takes some unaccompanied children and teen-age girls — Well run by adequate trained staff. Could do with more play equipment for toddlers. Otherwise standards of care and training excellent. Get grants from W.A.s. for mother-and-baby work and payment for them and other children and girls, who are, as a rule, placed there by W.A.s.

10. Hopedene:-
11. Kennedy House:- — Mother-and-baby Homes. Only registered in case they should ever have to keep an unaccompanied child temporarily.

12. Good Shepherd Convent:- Derry. — Only a few teen-age girls, the rest are older women.

13. Good Sheperd Convent:- Newry. — Material conditions and equipment very good. Girls and women work in laundry, have all amusements laid on inside Home. Quite happy atmospheré in both places.

14. Sacred Heart Home:- Good Shepherd Convent, Belfast. — Good material conditions. Could perhaps do with more play equipment, but would, I think, buy anything suggested to them. Have singing, elocution, dancing classes and girls go out to ordinary schools and to do shopping for Home. Not short of money, I think.

15. Rubane House:- — Good care and training by trained staff of Brothers - plus one woman cook. Is still in process of development, but on well organized lines.

16. Our Mother of Mercy Convent:- Newry. — Children go to outside school. This is also a Home for old ladies. The children look quite well-cared, and the babies very well-cared, but I feel there are insufficient staff, and the bigger children's activities could be improved.

17. Convent of Mercy:- Bessbrook. — Mainly a cheap boarding-school, on spartan lines, but affectionate care is given. Take a few voluntary children only. Said to have none when Dr. Simpson visited recently. Adequate care and training. Short of play equipment.

18. Nazareth Lodge:- Belfast. — Poverty-stricken. Short of staff and play equipment. Very institutional for older children, and babies in desperate plight. Rev. Mother very anxious to improve and hopes to have Nursery School started. Getting equipment already. ~~Trying to~~ make holiday arrangements.

19. Nazareth House:- Belfast. — Very institutional, but material conditions better than Nazareth Lodge. Short of play equipment. Short of staff.

/20. St. Joseph's Home

HIA 1464

Reference ____________________

20. St. Joseph's Home:- Termonbacca, Derry. (Nazareth Home)	Very institutional, but boys do get out to school, younger ones to Nazareth House, older ones to Christian Brothers. Short of staff; short of play equipment.
21. Nazareth House:- Derry.	Best play equipment of any of the 4 Nazareth Homes, at any rate for toddlers. Still very institutional.
22 Portadown Babies Home	

The children in these 4 Homes especially have nothing like a normal upbringing. They must feel unloved as it is just not possible for the number of staff to show affection to such large numbers of children. They can know little or nothing of the world outside, (as with one exception school is on the premises), and must be completely unprepared for it, either in character or knowledge. I find these Homes utterly depressing and it appals me to think that these hundreds of children are being reared in bleak lovelessness. This is not meant entirely as criticism of the staff, but their task is impossible. Some of them have, however, little idea of what a child's life should be. They have got used to their own institutional set-up. For example, when asked about the children going out, one replied "Oh yes, they go to the Circus at Christmas". If this is their sole contact with the world they must have a distorted idea of it! Even their "god-parent" scheme is unreal, as instead of getting ordinary folk somewhere near the children's own level to be "uncles and aunts" they have looked for business men who will give the boys jobs on leaving - regardless of whether the business is likely to suit the boy!

In short, I think we must press for complete overhaul of the whole set-up of these Homes, and assist them in every way possible

Kathleen B. Forrest
(K.B. FORREST)
28th April, 1953.

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Appendix 3: Home Office Memorandum on the Conduct of Children's Homes, 1952

HIA 469

[redacted]

GOVERNMENT OF NORTHERN IRELAND

Ministry of Home Affairs,
Stormont,
Belfast.

24 September, 1952

File No. T.8
Circular No. TC.25/1952

Sir/Madam,

With reference to the Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland), 1952, (S.R. & O. 1952, No. 131), of which a copy was sent to you on 1st September, I am directed by the Minister of Home Affairs to forward, for your information, a copy of a Memorandum issued by the Home Office in September, 1951, on the Conduct of Children's Homes.

Although this Memorandum has been prepared mainly with reference to Children's Homes in England, it contains various suggestions and advice which should prove of considerable assistance to members of staff of Children's Homes in Northern Ireland, and also to those who have responsibilities for the general management and maintenance of such Homes. The Ministry would, therefore, be glad if you would arrange to supply a copy of the Memorandum to everyone concerned.

Copies of the Home Office Memorandum (S.O. Code No. 34 - 349), may be obtained from Her Majesty's Stationery Office, 80 Chichester Street, Belfast, price 6d.

I am, Sir/Madam,
Your obedient Servant,

for SECRETARY.

[redacted]

The Secretary of each
Voluntary Home in Northern Ireland

21/-/35/9/52.

HIA 470

[redacted]

Memorandum by the Home Office on the Conduct of Children's Homes

INTRODUCTION

1. This memorandum on the conduct of children's homes has been prepared for the guidance of local authorities and voluntary organisations, and is intended to be read with the Administration of Children's Homes Regulations, 1951. The contents are based on experience gained by Home Office inspectors in visiting children's homes and on advice tendered to the Secretary of State by the Advisory Council on Child Care. It deals with the needs of children who, for one reason or another, cannot be boarded out and are brought up in children's homes; and it is written in the main with direct reference to children living as members of small groups of mixed ages and both sexes who are in care for an indefinite period and who look to the local authority or voluntary organisation for their upbringing. But most of what is said is applicable to all children's homes; and recommendations relating specifically to large homes are contained in Appendix I.

2. In paragraph 427 of their Report the Curtis Committee stated the main requirements for the substitute home in the following words:—"If the substitute home is to give the child what he gets from a good normal home it must supply:—

(i) Affection and personal interest; understanding of his defects; care for his future; respect for his personality and regard for his self-esteem.

(ii) Stability; the feeling that he can expect to remain with those who will continue to care for him till he goes out into the world on his own feet.

(iii) Opportunity of making the best of his ability and aptitudes, whatever they may be, as such opportunity is made available to the child in the normal home.

(iv) A share in the common life of a small group of people in a homely environment."

TYPE AND SIZE OF CHILDREN'S HOMES

3. The aim when providing new homes for children in long-term care is to enable each child to live as a member of a small group. The number of children in a home of this kind (referred to in this memorandum as a family group home) may vary from eight to twelve. If the home is a house in a street (perhaps a villa type house or two semi-detached houses, suitably adapted) the children gain by living as members of the local community and by taking a full part in its social activities as do children living with their own parents. Many local authorities are setting up small homes of this kind. Rather larger homes, taking up to about twenty children, are also being established. It is important that homes should be so situated that the children will be able, out of school hours, to mix with their school friends. While every children's home should have a garden, the children should be encouraged to join with others in outside play.

4. In the family group home, the age range should be wide, say from three to fifteen years, with boys and girls growing up together. It will be desirable sometimes to include children under the age of three in the group (for example, where they have older brothers or sisters in the home), or on occasion to keep

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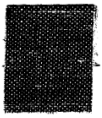

children beyond the age of fifteen. The conditions of normal family life can most nearly be reproduced in this way, and the children will not require to be moved at a specified age to some other children's home and so lose contact with those whom they are fond of and trust. In homes accommodating children of a wide age range and both sexes, the special problems arising in adolescence call for sympathetic guidance and wise, unobtrusive supervision. It will not generally be right to place in a mixed family group home older children coming into care, but this may not apply where several children from the same family are received into care and should be kept together.

STAFF

5. The standard of care provided in a home will be determined by the success with which the staff are able to take the place of parents and to meet the children's individual need for interest and affection. It is essential that the conditions offered to staff should be such as to attract and keep men and women of the high quality needed for this work.

6. It is on the understanding and devotion of the staff, more than on anything else, that the happiness of the children depends. The housemother and members of staff, besides being familiar with the stages of development throughout childhood, should be temperamentally fitted for the difficult task of maintaining the balance between giving the children the affection that they need and being too possessive in their attitude towards them. The housemother in charge of a family group home should be given the fullest possible responsibility, and should not be subordinate to the person in charge of some other children's home.

7. The staffing should be sufficient to allow the housemothers time to join in the children's activities and to talk with them, and thus to provide the children with the adult companionship which is necessary to their normal development. It is undesirable for one housemother to live alone with the children ; she needs adult companionship, and a housemother living alone may sometimes be subject to undue strain. In family group homes taking from eight to ten children, a resident housemother and assistant, or two housemothers, should be sufficient, with adequate domestic help. In homes taking eleven or twelve children, it will be an advantage to have in addition one full-time domestic assistant, preferably resident ; and in these the employment of a married woman as housemother, with the husband going to outside work, is a good way of securing a man's influence and interest in the household.

8. It is considered that the staff required for a home taking about twenty children of a wide age range and both sexes might be a married couple (the husband usually going to outside work), one resident housemother, one resident housemother/cook, daily domestic assistance, and part-time help with the garden where required.

9. If a home is to be well run it is essential that the conditions should be such as to enable the staff to retain pleasure and freshness in their work. Adequate time off and holidays, giving opportunity for outside interests, and provision for seeing their own friends in the home (see also paragraph 34), contribute to the well-being of the staff and consequently of the children ; at the same time, there should be sufficient flexibility in the arrangements to ensure continuity of care. Where relief staff are employed, it should be arranged, whenever possible, for the same people to go to the same homes.

10. It is hoped that local authorities and voluntary organisations will release suitable members of their staffs to take a full course in child care provided through the Central Training Council in Child Care, and will encourage others to attend refresher courses. A valuable feature of the refresher courses is the opportunity they afford to the staff of different homes to meet and discuss their work.

FURNISHING AND EQUIPMENT

11. The aim should be to create an environment, not luxurious but of a reasonable standard of comfort, in which both staff and children will feel at home and which will help the children to develop a proper pride in their surroundings.

Decoration and furnishing which are good in design and bright and attractive in colour will encourage the children to take an interest in their home, and to enjoy taking care of it. This applies equally to chair- and bed-covers, curtains and rugs, which should be in attractive colours but easily cleaned. There should be a room for play and a quiet room for reading and other such occupations; one of these rooms may serve also as the dining room. It will do much to produce the atmosphere of a normal home if staff and children share most of the rooms in the house, though the need of the staff for some privacy should not be overlooked. If there is not room in the house for a workshop for hobbies and crafts, the possibility of converting an outhouse or garage into a workshop should be considered.

12. The bedrooms should be furnished as far as possible as they would be in an ordinary household without uniformity, and there should be opportunity for the exercise of individual taste in the arrangement of furniture, the choice of colour schemes and the display of personal possessions. Sufficient chests of drawers and wardrobes should be provided to give each child space to keep his own clothes, and there should be bedroom rugs and a chair for each child. The need for bedroom mirrors for older boys and girls should not be overlooked. At least one of the rooms used by children should be furnished as a comfortable sitting room with easy chairs. Every child should have an individual place in which to keep his personal possessions; he should be entitled to regard this as a private place which should not be disturbed by the staff without his knowledge.

RECEPTION OF CHILDREN

13. As reception centres are established (see the memorandum which accompanied Home Office Circular No. 128/1949 of 4th July, 1949), the need for initial assessment in long-stay homes will diminish. It will be necessary however, for some time to place direct in long-stay homes children whose needs have not been assessed. Children may arrive at the home still subject to the strain and bewilderment of leaving familiar people and surroundings, and some may be suffering from the effects of ill-treatment or under-nourishment. Many of the recommendations contained in the memorandum on reception centres are applicable to the reception of children direct into long-stay homes. Children who have been in a reception centre will come to the long-stay home with a known history, and will have had time to get over the first effect of separation from their homes.

14. Where a child is to be admitted to a home, whether on coming into care or subsequently, it is of the greatest importance that he should be treated considerately; the need to put the child at ease and to gain his confidence should be reflected in the arrangements for the journey, and the escort should, if possible, be known to him. The housemother should have full information about the child before he comes, so that he can be greeted by name and made to feel that he is not a stranger. This kind of friendly welcome will be all the easier if it has been possible for him to visit the home once or twice beforehand. On arrival, he should be shown round the home and, if he has a brother or sister or friend there, he should see him at once. Children should be allowed to bring with them any personal possessions to which they are attached and these should be treated with respect. Children leaving a reception centre to go to a children's home should take with them clothes that they have become used to. Staff should not be discouraged if a newly admitted child does not respond to kindly approaches for a time, as this may be due to his distress at leaving home or to previous unhappiness or neglect.

RELIGIOUS UPBRINGING (REGULATION 4)

15. A child who has to grow up away from his own parents needs even more than any other the comfort and help of a religious faith and the inspiration to right thinking and right doing which it gives. A religious upbringing must be founded on the example of the people with whom a child lives: if they are sincere in their convictions, even though of a different denomination, the teaching

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and guidance that he receives will have added significance. Their influence will be seen in the development of his personal faith and of his sense of service to others.

16. A child's understanding of religion is quickened by the attitude and example of those about him; he will learn from them to say prayers suited to his age, and become familiar with Bible stories and with the lives of people whose faith has inspired them to serve their fellows. Unless it is impracticable, every child should attend the services and the Sunday school of his own denomination so that he may take his part in its observances and activities, and be prepared to become a full member of a corporate religious body. The house-mother should be ready to discuss with any child religious or other questions which he may raise, and where desirable to arrange for him to talk with a minister of religion or other adviser of his own persuasion with whom it is hoped that she will maintain friendly contact. The teaching which a child receives at his church, his Sunday school and at his day school will be strengthened in daily life by the sympathy and understanding of those around him in the home.

DAILY LIFE IN THE HOME

17. It is the practice in some homes, particularly large homes, for the staff to be known by names suggestive of institutional life, such as master or superintendent. Names like these are alien to the idea of family life, and their use by the children is to be discouraged. If a home is run in the right spirit, this will be reflected in the easy manners and the bearing of the children.

18. The aim of any routine should be to create for the children the feeling of security and well-being which is found in a happy family. Regular times for meals and for bed help to create a pattern of security in the child's mind. Within this framework there should be variety and sometimes the unexpected event or excursion. It may be unavoidable in the larger homes to announce some events of the day, such as meal times, by a gong or bell, but the children should be accustomed to telling the time by the clock and should be expected to practise punctuality as a way of showing consideration for others.

19. Much of the children's happiness as they grow up will depend on the ease and confidence with which they mix with other young people. Mealtimes in the home provide a valuable opportunity for social training as well as an occasion on which the group comes together as a family. The staff should have meals with the children, and should expect them to talk freely. Tables should be attractively laid, with flowers on the table whenever possible. The children should become accustomed at an early age to the use of knives, forks, spoons, tumblers and cups and saucers, and should be expected to pass dishes to each other and to help themselves. If meals are regarded as social occasions, it follows that ample time should be allowed for them. The older children should be encouraged to help the younger at meals, keeping in mind the need to teach the younger ones to look after themselves. It is unreasonable to expect the other children always to wait until the slowest has finished.

20. Each child should feel at bedtime that he is specially wanted and cared for. In many homes a bedtime story is told to the group; whether or not this is done, it is important that the housemother should find time to talk with each child as she says goodnight to him. In this way she will often hear the worries of the older children and will be able to give to each child the individual interest which he needs.

21. It is important that each child should have the hours of rest he requires; he should not go to bed unduly early or too late. As a general guide, the following hours of sleep are considered to be desirable:—

Age in years	*Hours of sleep*
1—2 ...	... 14—16 hours
2—4 ...	... 13—14 ,,
5—7 ...	... 12—13 ,,
8—10 ...	... 11—12 ,,
11—13 ...	... 10—11 ,,
14+ ...	... 9—10 ,,

22. Care should be taken to see that children are warm in bed at all seasons of the year; underblankets should always be provided. A feeling of warmth and comfort will play a part in preventing such happenings as night terrors and bed wetting.

23. Bed wetting cannot be attributed to any one cause; if effective help is to be given, the child must be studied as an individual. The trouble may be due to an organic cause, to delay in learning bladder control, or to emotional disturbance due to loneliness, a sense of being left in strange surroundings, or of not being wanted. A feeling of hopelessness about the habit may cause it to persist. A child who persistently wets the bed should be seen by the medical officer so that he can advise on treatment or, if necessary, refer the case to a hospital or child guidance clinic.

24. Understanding and consideration on the part of the staff are of the first importance. Bed wetters should not be separated from other children, and members of the staff dealing with the child or with the wet bed should proceed in a matter of fact way, and should never exhibit impatience, disgust or anxiety. Mackintosh sheets should be used only when necessary; when they have to be used, a thin blanket should be placed between the mackintosh and the bed sheet. Sheets should always be changed after being wet. Bed wetters should not be required to wash their sheets. There is nothing to be gained by restricting drinks unreasonably, but it is undesirable that any child should drink large quantities late in the evening. There should be easy and lighted access at night to a lavatory, and where necessary the children should have their own chamber pots.

RECREATION

25. Play is as necessary to children as food and sleep; through it they develop in mind, body and personality. Play should not be thought of only in terms of organised activities. The children should be given ample opportunity to play and amuse themselves in their own way, and should be encouraged in initiative, resource and self-reliance. They should be taught to use the facilities of the neighbourhood, for instance, the public library, and allowed a reasonable choice of their own books.

26. Indoors, the children should have a varied supply of play material, including materials for dressing up; hobbies should be encouraged, and opportunity given to look at picture books, to read newspapers and periodicals suited to their age, and to listen to the gramophone and wireless. Children should be encouraged to choose their programmes, and not have the wireless on continuously. There should be small tables at which the children may play games or pursue hobbies, and arrangements should be made, if possible, for a child to have some place where a half-finished model or other cherished piece of work can be left with safety.

27. Fresh air, sunshine and activity are essential to the health and the full physical and mental development of children. Much of their time should be spent out-of-doors. Where the garden is large enough, part of it should be set aside for the free use of the children. Sand-pits in suitable conditions and if properly looked after, provide happy occupation for small children. The keeping of pets gives children the experience of caring for living things and develops a sense of responsibility. Bicycles, besides being popular, provide training for the older children in independence and road sense. The children should be taught to look after the bicycles as well as to enjoy their use. Outings and treats should be arranged. As opportunity offers, the children should be helped in the observation of growing and living things and in the life of the countryside.

PERSONAL HYGIENE

28. Children need training in how to use and look after their toilet articles, which they should regard as their own property and be able to identify easily. Individual towels, face cloths, tooth brushes (with individual tooth paste or powder) and brushes and combs should be provided and clearly marked by name or initials, or, in the case of children too young to read, by symbols which they can

recognise. Towels should be hung so that they dry and are not in contact Supervision may be necessary in the use and care of these articles, but the aim should be to train the children as quickly as possible in habits of personal cleanliness and independence. Baths, with clean water for each child, should be taken at least twice a week, just before bed, and the children should be trained to bath themselves. Bedtimes naturally vary with the ages of the children, and it should be possible to plan some bathing each night without interfering with evening activities. The children's hair should be washed regularly, and attention given to the cleanliness of their heads. Children should be trained in regular habits and encouraged to report constipation ; an aperient should never be given as a matter of routine, but only where it is required in the individual case. The needs of the adolescent girl should be provided for.

DRESS AND FOOTWEAR

29. Uniformity of dress is to be avoided. The disadvantages of central purchasing should be weighed against its advantages. There should be variety, and opportunity for individual choice. Children attending school or a youth organisation should wear the kind of clothes that are required. From an early age, children should accompany the housemother when she is buying their clothes. Older children should be taught something of the prices and suitability of clothes and materials, and the girls should be encouraged to make attractive clothes for themselves. Uniformity should be avoided also in such matters as the dressing and cutting of hair.

30. Great care should be taken to provide children with correctly fitting boots and shoes. They must be of adequate length with flexible soles to allow proper use of the foot muscles, and the heels should fit comfortably. The passing of part-worn footwear from one child to another carries with it the risk of injury and possibly infection to the feet: where it is done, only well-fitting boots or shoes which are in good condition and not in any way misshapen should be passed on. It is important also to see that the feet of socks or stockings are of sufficient length after laundering as well as when new.

MONEY AND PERSONAL POSSESSIONS

31. Learning to handle money is an essential part of a child's training in everyday matters. Children should have a reasonable and known amount of pocket money. While pocket money will usually be given weekly, it may be helpful on occasion to give a larger sum for a longer period so that the experience of weighing the usual limited expenditure against the making of some special purchase may be possible. Older children should be allowed whenever possible to undertake shopping for the home, and to buy things for their own use. Younger children should be allowed to accompany the older children or housemother on shopping expeditions, and themselves be trusted to make simple purchases such as small birthday presents. Those nearing school-leaving age might be given an allowance to cover the purchase of clothes and personal necessities and so learn to take a greater pride in their own things. Unless some arrangement of this kind is made, a child may start work without knowing how to lay out money on personal needs.

HELP IN THE HOME

32. Boys and girls should be expected to take a moderate share in the daily running of the home, but not at the expense of sleep, meals, education or reasonable recreation. Young children should not be discouraged from trying to help in the house. Older children, in assisting members of staff, should progress from light routine tasks, such as dusting, bed-making and washing up, to skilled work, such as cooking, bottling, ironing and making things for the home. It is sometimes forgotten that a share in the running of the house means a share in the interesting as well as in the dull occupations. Older children could be given some responsibility for planning meals, purchasing household goods and checking the laundry, and should have opportunity of attending demonstrations or exhibitions of domestic interest in the neighbourhood.

CONTACT WITH RELATIVES AND FRIENDS

33. The child's link with his own family and relatives should be preserved wherever possible, and the staff of the home can help to strengthen the link by getting to know visiting parents. Visits by relatives and friends should be encouraged, and there should be no undue restriction as to times. Normally, the letters sent and received by a child should not be read by the staff of the home; exceptionally, the head of the home after consultation with the children's officer in the case of homes provided by a local authority, may find it necessary to supervise correspondence.

34. It is essential that children should learn to make friends outside the home and should be used to meeting other young people and to visiting ordinary homes. Both children and staff should be encouraged to invite their friends to the home; the children may thus experience the pleasure of giving as well as receiving hospitality. It is important that a child who has no parents or other relatives who visit him, or whom he visits, should be befriended individually by local people who are on friendly terms with the staff of the home. Women's Voluntary Services, Youth Organisations, Rotary Clubs and other bodies are ready to make arrangements of this kind for children in homes.

HOLIDAYS

35. The summer holiday is an important event in the lives of children, and it is specially desirable that children who are being brought up in children's homes should have an annual holiday of the kind best suited to their needs. In a family group home, there is something to be said for the group going away together for the children's holiday, the children sharing their experiences with those who look after them in the home. Children who lead a community life in larger homes will be likely to benefit by a complete change of surroundings, such as may be found with suitable relatives or in private foster-homes where they may see something of normal family life. Members of youth organisations, such as scouts and guides, should be given opportunity to go to camp or to take part in other holiday arrangements. There will be scope to arrange for older children to join others in using youth hostels. Organised camps or holiday homes, catering for large numbers, should be used with discrimination; younger children are likely to find such places exhausting. The aim should be to arrange as far as possible for each child to have the kind of holiday which, beside giving him pleasure at the time, will widen his interests and provide him with those experiences and memories which are so important in the pattern of young lives.

DIETARY

36. Menus should be varied and well-balanced. Contact should be maintained with the local Food Office so that ration permits may be altered as circumstances change. Breakfast should be served always within one hour of rising and should include a main dish. Mid-day dinner will often be taken at school. Where this is not done, application should be made for the additional food allowed for five main meals a week based on "school meals" rations, and dinner should generally consist of meat or fish and two vegetables (green leafy vegetables being served about three times a week) followed by a suitable pudding. The children should have a high tea (including, whenever possible, meat, fish, cheese or egg) and a light supper; alternatively, if preferred for the older children, a light tea and a substantial supper should be provided. Children should be encouraged to drink sufficient water, which should be readily available between meals and at meals.

37. Protein should be given twice daily, and can with advantage be included in all three main meals. Adequate quantities of salads and fresh fruit should be given. Milk should be tuberculin tested or pasteurised, and each child should have not less than a pint a day, including school milk. Children under five should have the special allowance of cod liver oil and orange juice available for them. Regulation 3 and the Schedule, item 5, require records to be kept of the food provided. The records should be examined from time to time by persons visiting the home on behalf of the local authority or voluntary organisation.

The Ministry of Health have published a booklet, "Feeding the One to Fives," obtainable from H.M. Stationery Office (Sales Offices), price 6d. (post free, 7½d.), or from any bookseller.

MEDICAL ARRANGEMENTS

39. Regulation 5 requires the appointment of a medical officer for each local authority and voluntary home. His duties include regular attendance at the home and, as far as practicable, the periodic routine examination of the children, the provision of suitable medical attention as required, the supervision of medical records, and general supervision of the health of the children and hygiene of the premises. He should take an interest in the progress of the children and in their general welfare. It is, therefore, desirable that he should visit frequently, and get to know the children and the staff. Regular visits will enable the staff to keep him informed of matters which are not of sufficient consequence to justify a special call. The fullest possible information as to the previous medical history of each child and his family should be available to the medical officer. It is particularly important that this should include details of any immunisations. Regulation 6 requires arrangements to be made for dental care of the children.

40. Sick children can be provided with treatment under the National Health Service, but payment will have to be made for the general supervision and the routine examinations which are outside its scope. Although it is desirable that one doctor should undertake all the duties of medical officer, a local authority may have to make special arrangements for their homes by employing their own medical staff.

41. The advice of their Medical Officer of Health could be sought with advantage on all medical matters affecting homes provided by a local authority, including the appointment of the medical officer for the home, matters concerned with the health of the staff, precautions against the spread of infectious disease, and, where appropriate, the medical aspects of the planning of accommodation. Voluntary organisations may also find it an advantage to seek the advice of the appropriate Medical Officer of Health on such matters. It is desirable for the local Medical Officer of Health to be informed of the outbreak of any non-notifiable disease, such as gastro-enteritis, in any children's home.

42. It is recommended that the frequency of medical examinations, of dental inspections, and of other routine arrangements should be as follows:—

(*a*) *Medical examination*—
On admission.
At least monthly for children aged 0—1 year.
At least quarterly for children aged 1—5 years.
At least yearly for children over the age of 5.
On discharge.

(*b*) *Weight (in a single garment)*—
On admission.
Weekly—for children aged 0—6 months.
Monthly—for children aged 6 months to 2 years.
Quarterly—for children aged 2 years and over.
On discharge.

(*c*) *Height (for children aged 2 years and over)*—
On admission.
Quarterly.

(*d*) *Dental inspection*—
This is very desirable for children over the age of 2 and, if possible, should be arranged shortly after admission and at intervals of not more than six months.

(*e*) *Medical records*—
Individual records should be kept showing condition on admission, and progress, and should include a record of sickness. Dates of immunisations should be noted. Condition on discharge should be recorded.

Suitable medical record cards for children aged five and over, and similar cards for children under the age of five, can be obtained from H.M. Stationery Office (Sales Offices), price 15s. 2½d. per hundred for the cards, and 10s. 2d. per hundred for the continuation cards including purchase tax in each case. The cards should be ordered under the references "Home Office RHM" for children aged five and over, and "Home Office RNM" for children under five, and the continuation cards under references "Home Office RHM (C)" for children aged five and over, and "Home Office RNM (C)" for children under five. The cost of the carriage is 1s. 2d. per hundred for the cards and 10d. per hundred for the continuation cards. (See Home Office circular 18/51 of 23rd January, 1951 and circular letter of 23rd January, 1951.)

43. Children attending local education authority schools will be examined by the school medical service at intervals. A member of the staff of the home should endeavour to be present, and should tell the doctor anything of note about the child just as a parent would.

44. While a good standard of cleanliness should be maintained in the home, this need not be carried so far as to produce an institutional atmosphere. Personal cleanliness among those employed in the kitchen is essential, and kitchen waste should always be stored in covered bins pending removal. The larder window should be efficiently fly-proofed, but should allow adequate ventilation.

45. When numbers of children live together there is a risk of epidemics and precautions must be taken to prevent the spread of infection. One of the most important methods (too often neglected) of preventing epidemics is the early diagnosis and isolation of the first case. The sick room, which should be a bright room and within call of a member of staff, should be ready for immediate use. In homes for fewer than about twelve children, arrangements should be made to enable a suitable room to be brought into use as a sick room at any time. If a sick child has to be kept apart from the others he should be provided with toys or books or suitable interests, and will need extra attention and mothering. If a child has to be admitted to hospital, the staff of the home should keep in frequent touch with him both by letters and visits, and there should be no delay in taking him back when he is ready for discharge.

46. In view of the close contact between staff and children, it is desirable to safeguard the well-being of the children by ensuring, as far as is possible, that the staff are free from any disorder likely to harm the children. A medical examination, including an X-ray of the chest, before appointment, and an X-ray of the chest subsequently at yearly intervals, is advisable, and local authorities and voluntary organisations are recommended to consider what measures should be taken to this end, and to consult the Regional Hospital Board as to ways and means of arranging for X-ray examinations.

SAFETY PRECAUTIONS (REGULATIONS 8 AND 9)

47. The advice of the Chief Officer of the Fire Brigade should always be obtained on fire precautions and on fire drills. The subject is dealt with in full in Appendix II. Open coal, electric or gas fires should be provided with fixed fireguards, and in rooms used by young children, radiators and hot pipes should be suitably guarded. Medicines and disinfectants should be kept in locked cupboards to which children cannot get access. Where windows, verandahs or staircases are potentially dangerous, or where there are main roads, ponds, rivers, etc., in the vicinity, the risks should be assessed, and suitable safety measures taken.

DISCIPLINE

48. Some form of discipline is necessary in every community, if the general well-being is to be maintained. Most children are difficult at times, and those coming into care may be specially difficult at first. Many will be disturbed by removal from their homes, and some will never have had a chance of learning to consider the interests of others. Measures taken to preserve discipline should not be such as would be likely to undermine the self-respect of children or to lessen their sense of responsibility for their actions. In general, the consideration and courtesy shown by members of the staff to each other and to the children will provide the example which is likely to influence in the right way all members of the group.

49. The difference in the relationship existing between staff and children and between parents and their own children calls for a careful approach to discipline in a children's home. Children who have lacked affection previously and who have become possessive and jealous about persons or things will need considerate treatment; it would be useless, and often harmful, to punish for this kind of behaviour. Where, on the other hand, correction is needed, it should aim at helping the child towards self-discipline and a developing sense of responsibility towards the people with whom he lives. It is by patience and interest, and the understanding of each child's problems and needs that the staff will win response and loyalty from the children.

50. Appendix III deals with the subject of discipline and the effect of the relevant Regulation.

EDUCATION AND THE HOME

51. Local authorities and voluntary organisations should do all that interested parents would do to enable a child to obtain and take advantage of opportunities of education and training suited to his ability. In the children's interests, the staff of the home should keep in close touch with the school and watch each child's progress there. The children should be given every facility to enable them to take part in handwork, sewing and cookery classes, and, if they wish, to buy the things they have made. They should be free to join in out-of-school activities. Children should always have a quiet place at home where they can do their homework undisturbed.

52. Training in health and hygiene is one of the responsibilities of the housemother, and in this she will be helped by the teaching given in most schools. Children are interested in their physical development, and want factual information about it as they grow up. The housemother should be ready to answer questions in a way appropriate to the age and intelligence of the child.

53. The staff of the homes should take advantage of the opportunities offered by many schools through parent-teacher associations and open days to acquaint themselves with the life of the school. Children's enjoyment of prize-giving, sports day and school functions may be greatly increased by having present someone belonging to them.

CHOICE OF EMPLOYMENT

54. When children are ready to leave school and go out to work advantage should be taken of the facilities provided by the Youth Employment Service for advising them on their choice of a suitable occupation and helping them to find satisfactory employment. Children usually come into contact with the Service through the schools they are attending. Youth Employment Officers visit schools and give preparatory talks on the choice of employment to groups of boys and girls in their last year at school, and at a later stage arrangements are

made for school leavers to be interviewed by a Youth Employment Officer and to receive personal advice about the type of work best suited to their individual capacities. It is important that children in homes should attend for interview, and that a member of the staff of the home who knows the child's aptitudes and particular interests should be present. The placing facilities of the Youth Employment Service are available not only to young people on leaving school but at any time up to the age of eighteen. The Service has also certain responsibilities for keeping in touch with the boy or girl after he has been found work and until he reaches the age of eighteen. The objects of this procedure (called "review of progress") are to ensure as far as possible that the placing has been satisfactory, and to provide young workers with opportunities for discussing their progress and their problems with a Youth Employment Officer and for receiving such further vocational advice and assistance as may be necessary. The Youth Employment Service administers a scheme of training and maintenance grants under which young workers with special aptitude for a particular skilled industrial occupation (for which training facilities are not available within daily travelling distance of their homes) can receive financial assistance to enable them to take up training in that occupation with employers in other areas. Youth Employment Officers welcome the co-operation of those concerned with the care of the children. Those responsible for homes in which education is provided within the premises should ensure that full use is made of the facilities provided by the Youth Employment Service.

PROVISION FOR CHILDREN ON LEAVING CHILDREN'S HOMES

55. It is recognised that the transition to life outside cannot always be easy for those who have been brought up in a children's home. It is accordingly important that the older children should be prepared for this and should be given every opportunity to become self-reliant. For example, it will be helpful if they can have for a time before they leave a room of their own to accustom them to the conditions of increasing independence. It will usually be desirable for children to leave the home on reaching school-leaving age, or soon afterwards, although there can be no hard and fast rule and it may be right in exceptional cases for children to remain in the home beyond that age. The retention of girls in homes to do domestic work is deprecated. While children should leave the home well-equipped, they should retain some familiar articles of clothing as well as taking with them their personal possessions.

56. Section 19 of the Children Act, 1948, empowers local authorities, with the consent of the Secretary of State, to provide hostels for young people who are or have been in care and have reached school-leaving age. Where hostels are provided, local authorities should make use of their power to accommodate in them young people who have not been in the care of a local authority, and thus to enable those who are, or have been, in care to meet and live with others from ordinary homes.

AFTER-CARE

57. Where a child has left the care of a local authority or voluntary organisation since reaching school-leaving age, the local authority in whose area he is living, unless satisfied that the welfare of the child does not require it, have a duty to advise and befriend him until he reaches the age of eighteen. This task will normally be undertaken by the children's officer and staff, but the local authority, if satisfied in the case of a child who has left the care of a voluntary organisation that the organisation have the necessary facilities, may arrange for the voluntary organisation to undertake his after-care. The housemother or housefather should have a close link with the child, and co-operation between them and those responsible for after-care will often be of value.

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58. It is hardly practicable to confine consideration of this subject to the records which should be maintained in respect of children who are in children's homes. For this reason, what follows is related to the maintenance of records in respect of all children in the care of local authorities and voluntary organisations.

59. It is essential that a comprehensive record should be kept of every child in care. These records will provide the material on which informed decisions about a child's future can be taken, and will form a continuing account of a child's progress including his progress at school. They will serve also as a means of checking whether action that should be taken has been taken, for example, whether a child should be restored to his parents, whether a child should be boarded out, and whether, if he is boarded out, the requisite visits have been paid to the child in his foster home. The building up of reliable records is not easy, and the staff should be given a full allowance of time for this work, which will be of value not only in relation to the individual child but also in the wider field of improving the knowledge of the treatment of children in care.

60. There should be a personal case history for every child in care. This might consist of a folder containing:—

(*a*) The basic record of all relevant information about the child and his family, including reports completed at the reception centre;

(*b*) history sheets with a continuing record of matters of consequence in the child's life, including relevant information about his health;

(*c*) copies of all reports, including school reports, court orders or correspondence concerning the child; and

(*d*) certificates, including birth certificate, photographs and other papers which the child may like to have later.

61. It will be wise to keep the entries in the history sheets factual and as simple as possible. Opinions about a child change and may vary from worker to worker; over-elaboration should be avoided, as records can quickly become the master and not the servant of those who use them.

62. It may not always be easy for the local authority or voluntary organisation to decide to whom the full records of the children should be made available. In the case of a local authority, it is to be expected that they will be seen by the children's officer, and the boarding out or other field staff concerned with the child's supervision. It is considered that the person in charge of a children's home should ordinarily have full information about the children. When a child is boarded out, sufficient information (including information about his health) should be given to the foster parent. In general, it is to be expected that it will be to the child's advantage if those immediately responsible for his care are informed about his background.

63. When a child is placed in a children's home, it will be for the responsible officers of the local authority or of the voluntary organisation to decide in what form information is to be given to the person in charge of the home. It is suggested that a copy of the basic record, a summary of relevant information contained in the history sheets, and copies of reports of interest should usually be given.

64. A central register of children in care is no doubt maintained by all local authorities and large voluntary organisations, and this would serve as an index to the personal case history folders. The records to be maintained by children's homes may be summarised as follows:—

(*a*) record of children admitted to the home, showing name, date of birth, religious persuasion, dates of admission and of leaving, and a record of absences;

(*b*) daily register of children in the home;

(*c*) personal case history for each child in the home, with a continuing record of matters of consequence in the child's life ;

(*d*) log book of events of importance in the life of the home ;

(*e*) records of the food provided ;

(*f*) record of weight and height (see paragraph 42 above) ;

(*g*) punishment book.

It is intended that the log book mentioned at (*d*) above should contain not a list of occurrences of everyday interest, but a record of events of importance such as affect materially the running of the home, that is, matters of which an official visitor to the home should take account. (See Regulation 3 (2) and the Schedule as to the records required to be kept.)

CONCLUSION

65. The success of family life within a children's home will be seen in the degree to which a child who has been brought up there feels himself to be an individual with rights and responsibilities, equipped to take his place in the world. Every aspect of life within the home should contribute to this end, since the aim of all that is done is to produce stable, happy and self-reliant citizens.

HOME OFFICE.

July, 1951.

APPENDIX I

(*See paragraph* 1 *of the memorandum*)

RECOMMENDATIONS RELATING SPECIFICALLY TO LARGE HOMES

1. This appendix contains recommendations relating specifically to large homes, and particularly to those which are organised neither as grouped cottage homes nor as boarding schools. The appendix is to be read in conjunction with the memorandum which, though written in the main with direct reference to children in care for an indefinite period who are being brought up in family groups, applies for the most part to all long-stay children's homes and, with necessary modifications, to short-stay homes.

2. The size of some homes, and the nature of their premises and organisation, are such as to make them in greater or lesser degree institutional in character and thus particularly unsuitable for young children. It is of the first importance that all possible steps should be taken to lessen the disadvantages of the large home.

3. Where the children do not go out to school, the home should be run as far as possible as a boarding-school with arrangements for the children to spend the school holidays with parents, relatives or foster-parents. It will be all to the good if some of those attending such a school are children living in their own homes. In other cases, the home might be organised, after suitable adaptation of the premises, in family groups, each under the charge of a house-mother, so that the conditions of a family group home are reproduced as nearly as possible. Where the nature of the premises makes this impracticable, it may be possible to adopt a house system. Whatever the method of organisation, the aim should be to secure that certain members of the staff have continuing responsibility for the care of certain children, so that constant change is avoided.

4. A defect of some large homes is that there is insufficient recognition of a child's need of occasional privacy, and that the children may never know what it is to be alone. Some small rooms, comfortably furnished and provided with small tables for study and quiet occupation, should always be available. There will be need for rooms with equipment for games and physical exercise, and for play in bad weather.

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5. Reference is made in paragraph 17 of the memorandum to the undesirability of the children's using names suggestive of institutional life, such as master or superintendent, which are alien to the idea of family life.

6. The serving of all meals for the whole home in a central dining room is not conducive to a family atmosphere or to social training, and should be avoided where possible. As far as practicable, the staff should take their meals with the children who should usually be kept within their own family or house group at table, with their own housemother or housefather. Wherever possible, the housemother should give her children at least one meal a day (perhaps tea) in a room set aside for the use of the group

APPENDIX II

(*See paragraph 47 of the memorandum*)

ON FIRE PRECAUTIONS

1. All children's homes must have adequate fire precautions and means of escape, but the measures to be adopted will vary widely with the age and number of the children and the type of building; the extensive precautions necessary in a large nursery, for example, will have no place in a family group home. The aim should be to provide for the safety of the children without adopting measures which are over elaborate or which might tend to differentiate the home too much from neighbouring premises.

2. The Chief Officer of the Fire Brigade should be asked to arrange for visits to all children's homes, and to advise on the suitability of the measures already adopted; he should be consulted also at the planning stage when premises are to be adapted to provide a home or when a new home is to be built. He should be asked to advise on fire drills, and, if there is no standing arrangement with the manufacturers for maintenance, to inspect patent fire extinguishers and other apparatus which may deteriorate.

3. Although the necessary fire precautions will vary widely, some features are common to most homes. The provision of adequate alternative means of escape, a simple but efficient warning system, and a method of rapid communication with the fire brigade are essential; fire drills should be held at frequent but irregular intervals to accustom the children to a routine that they may have to carry out in emergency. A good time for surprise drills is shortly before normal waking time. The need to hold fire drills more frequently in short-stay homes than in long-stay homes should be borne in mind.

4. While fire precautions and means of escape must be adequate, care should be taken to see that as far as possible they do not interfere with the running of the home or mar the internal or external appearance. This is particularly important with family group homes which, for example, will often be given an institutional appearance by an external steel fire escape; where an external escape must be provided, it should be sited, if possible, at the side or rear of the house. Similarly, internal escape ladders should be sited so that they do not restrict unduly the use of the rooms or spoil the appearance of living rooms. Escape hatches should be placed so as to interfere as little as possible with the normal life of the home.

5. Means of escape such as patent lowering lines, transportable ladders, chutes and similar equipment have various disadvantages and cannot usually be recommended with any degree of confidence for use in children's homes.

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APPENDIX III

(*See paragraphs* 48 *to* 50 *of the memorandum*)

ON DISCIPLINE

1. Reasonable compliance with a code of conduct devised in the interests of the group is necessary, and this can be secured as children become socially adjusted. There may be special difficulty in the case of adolescent children who come into care and who have not learned to live as members of a group. Children can be helped most effectively by staff who understand their needs and can exercise imagination in their relations with them; an important factor is that children should be confident of, and secure in, the immediate and continuing interest of the staff.

2. Speaking broadly, happy children are good children. All children are naughty sometimes; their growing sense of personality leads them to trials of strength with authority and with each other. But if a child misbehaves persistently, there is need to discover what is wrong. Misbehaviour may be only naughtiness which can be dealt with by simple corrective measures, or it may be irrational conduct due to some underlying emotional disturbance, or a mixture of both. In the second case, punishment is not likely to eradicate it; those in charge of the child should direct their efforts to seeing that his difficulties are resolved. A child may, for instance, behave aggressively, sometimes because of an emotional disturbance such as jealousy, or a sense of inferiority, sometimes because he has found that it pays in getting his own way. In the one case, the feeling of jealousy or inferiority must be cleared away; in the other, the child has to be educated to control his desires and harmonise them with the interests of other individuals and of the group.

3. When correction is needed it should aim (as is suggested in paragraph 49 of the memorandum), at helping a child to develop self-discipline and a sense of responsibility towards the people with whom he lives. It should follow the fault as quickly as possible and, once over, the matter should not be brought up again. The aim should be to correct the child in such a way as to bring home to him the effect of his action on the group. Measures which are purely punitive in intention and effect make no contribution to a child's education.

4. As long as correction does not take a form which is likely to damage a child's self-respect, it is usually to his advantage to feel that he has paid for his fault and that the account is closed. Some deprivation of treats or of special kinds of food (for example, ices or a portion of his sweets) may be justified on occasion. At the same time, the privileges and treats which children enjoy should be regarded as a normal part of the life of the home and not as things which are given or withdrawn by way of reward or correction. The withholding of normal meals is open to objection, as is the practice of keeping a child in bed during the day. Regular meal times and bed times help to convey a sense of security, and interference with them as a punishment should be avoided. An early bedtime may be the right course to take with a child who has become irritable through tiredness.

5. It may be right sometimes to make a child help someone whom he has hindered by bad behaviour (taking care that help in the home is not degraded to the level of a punishment), or to give up some part of his pocket money towards the cost of making good something that he has spoilt wilfully or through disobedience or wanton carelessness. It is important that children should not be left with a sense of resentment. For this reason, mass punishment for the offences of individuals cannot be justified.

6. The effect of Regulation 11 is to prohibit corporal punishment of any kind, except:—

(*a*) smacking the hands of boys and girls under the age of ten; and

(*b*) caning (applied by the person in charge of the home), in the manner and to the extent permitted by the Regulation, boys who have reached the age of ten but not school-leaving age.

7. The provision for corporal punishment as referred to in the preceding paragraph has been included in the Regulations for use as a last resort. While it might seem natural to smack the hand of a small child in need of correction, to practise this indiscriminately would be to risk aggravating the condition of some children, who are troublesome because they are emotionally disturbed as a result of past experience. Although provision for corporal punishment has been made in the Regulations, it is open to any local authority or voluntary organisation to instruct their staffs that it is not to be used.

8. The Regulations do not attempt to prohibit specified punishments (other than corporal punishment of a kind not provided for in Regulation 11), because there would be inevitable omissions from any list of objectionable punishments. For example, no person with understanding of children could think a punishment suitable which had the effect of frightening a child, of isolating him from his fellows, or of leaving him unoccupied for long periods. Children should never be shut in dark places, or "sent to Coventry," or made to wear distinctive dress or left for long in an empty room. If it is necessary to remove a child from companions because he is hysterical or for some other good reason, one of the staff should be with him or within reach so that he cannot feel himself deserted. The setting aside of a quiet room may in itself provide a refuge for a child who needs to be alone.

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Chapter 3:

Findings

Contents **Para**

Findings

1 In this Chapter we set out our findings volume by volume in respect of each module, preceded by a brief introduction explaining the institution(s) or topic examined by the Inquiry in that module. The full report in respect of each module will be found in the volume and chapter identified below at the start of each section. Because of limitations of size we have grouped the chapters relating to institutions and topics in each volume in sequences that are not necessarily in the order in which each module was dealt with by the Inquiry, but reflects a thematic link between the chapters.

2 We have arranged the chapters relating to each institution or topic in volumes in a sequence that enables the reader with a particular interest in several institutions or topics to find the chapters relating to those institutions or topics in the same volume or the preceding or succeeding volume. Thus we placed the chapter on child migration to Australia between the chapters relating to the Sisters of Nazareth homes in Derry and Belfast because the Sisters of Nazareth sent most of the children to Australia from Northern Ireland on the Child Migrants Scheme. The chapter on Fr Brendan Smyth was placed after the last chapter relating to the Sisters of Nazareth homes but before the chapter on Rubane House because he abused children in both homes. The chapters on Rubane and St Patrick's Training School were placed together in Volume 4 because both institutions were run by the De La Salle Order. The chapters relating to all the other juvenile justice institutions have been placed in Volume 5. The chapters in Volume 6 all relate to voluntary homes that were not run by central or local government, or by statutory authorities. Because of their size the five chapters relating to the Kincora Boys Hostel have been placed in Volumes 8 and 9, and Volume 10 consists of the report by the Acknowledgement Forum.

Volume 1 – Chapter 1 – Introduction

3 This explains the origin and Terms of Reference of the Inquiry, its structure, procedures and practices, as well as a brief overview of the social and economic background of Northern Ireland against which the residential institutions examined by the Inquiry have to be viewed.

Volume 1 – Chapter 2 – Governance and Finance

4 This chapter examines in detail the legal and government structures within which residential institutions operated during the period covered by the Inquiry's Terms of Reference, and the funding arrangements for those institutions. We made one finding in this chapter. While we do not underestimate the demands on the limited number of staff in SWAG (the Social Work Advisory Group) in the 1970s and early 1980s and recognise that they were contributing to policy developments and consultations at that time as well as maintaining some limited contact with children's homes. We accept that the visits SWAG made to children's homes meant that the children in those homes had the benefit of some external scrutiny of the conditions they were living in and the care they were receiving. However, as will be clear from our findings in relation to individual children's homes we found the lack of inspection by SWAG in this period amounted to a systemic failing by the Department of Health and Social Services (DHSS) to ensure these homes provided proper care.

Volume 1 – Chapter 3 – Summary of Findings

5 In this chapter we briefly explain the nature of each institution or issue examined by the Inquiry during its public hearings, followed by a summary of the findings of the Inquiry in respect of the issues examined in respect of that institution or issue. As these are summaries, it should be noted that some headings may encompass several distinct findings of systemic failings of the same type. The summary is not meant to replace those findings, and the individual findings in each chapter represent our definitive findings.

Volume 1 – Chapter 4 – Recommendations

6 This chapter contains the recommendations of the Inquiry relating to an apology and a memorial, together with the Inquiry's detailed recommendations as to the scope of financial redress to be made to those who were abused while in residential institutions and homes within our Terms of Reference.

Volume 2 – Chapter 5 – Module 1 – Sisters of Nazareth, Derry

7 The Inquiry devoted Module 1 to the examination of evidence relating to two homes run by the Congregation of the Poor Sisters of Nazareth in Londonderry, namely St. Joseph's Home, Termonbacca, and Nazareth House in Bishop Street. For simplicity's sake we referred in this chapter to St. Joseph's Home, Termonbacca as "Termonbacca" as this was the name by which it was commonly referred to by witnesses and officials alike. These institutions were dealt with in the same module because there are a number of overlapping features of the manner in which they were run and other links between them although we examined them separately.

8 The Inquiry devoted thirty-nine sitting days to this module commencing on 27 January 2014, spread over ten sitting weeks from 27 January to 29 May 2014. During the ten sitting weeks, one of which (week 6) was a closed session, the Inquiry received oral evidence from sixty-two witnesses and received written statements from a further ten witnesses. The evidence of one other witness was not admitted because they failed to turn up or give a reasonable explanation for not doing so.

9 In addition to the oral and written evidence we have taken into account the detailed written and oral closing submissions made on behalf of fourteen individuals against whom allegations of abuse were made, and we also received written and oral admissions on behalf of the Congregation of the Sisters of Nazareth, the Department of Health, Social Services and Public Safety, as the successor department to the Ministry of Home Affairs and the Department of Health and Social Services, each of which had statutory responsibility for these homes during the period with which we are concerned.

10 We also received oral and written submissions on behalf of the Health & Social Care Board, as the successor to the various local or statutory authorities which had responsibilities for the care of children in this area. We considered all of this evidence and paid careful attention to the various written and oral submissions which were made to us, however in accordance with our general approach and our Terms of Reference, we do not propose to refer to each and every detailed allegation that was made, whether against an individual or either institution, although we have taken all of the evidence and the submissions into account.

Findings in respect of the Sisters of Nazareth at Termonbacca

11 There was abuse in the form of improper sexual or physical behaviour by individual sisters towards children in their care.

12 There was abuse in the form of improper sexual or physical behaviour by other adults, employees, visitors and priests towards children in the care of the Sisters of Nazareth.

13 There was abuse in the form of improper sexual or physical behaviour by older children towards children in the care of the Sisters of Nazareth.

14 There was emotional abuse in the form of improper behaviour by individual sisters towards children in their care which undermined the self-esteem and emotional well-being of the children.

15 There was emotional abuse in the form of improper behaviour by other adults, namely employees, visitors and priests towards children in their care, behaviour which undermined the self-esteem and emotional well-being of the children.

16 Individual sisters and those in positions of authority within the Congregation at Termonbacca were aware of the matters above.

17 Although there was evidence of poor childcare in some respects, we consider this did not amount to systemic neglect.

18 No, or alternatively inadequate, steps were taken by the Sisters of Nazareth to prevent such abuse.

19 Individual sisters, and those sisters in positions of authority within the Congregation, did not take proper steps to report such abuse to the relevant civil authorities, namely social services and the police.

Findings in respect of the Sisters of Nazareth at Bishop Street

20 There was improper physical behaviour by individual sisters towards children in their care.

21 There was improper sexual behaviour by a visitor and by priests towards children in the care of the Sisters.

22 There was improper physical behaviour by older children towards children in the care of the Sisters.

23 There was improper behaviour by individual sisters towards children which undermined the self-esteem and emotional well-being of the children.

24 The Sisters of Nazareth were aware of the abuse and took no steps to prevent such abuse.

25 The Sisters of Nazareth did not take proper steps to report such abuse to the relevant civil authorities, namely social services and the police.

26 The Congregation of the Sisters of Nazareth did not take adequate steps to ensure that they had:

(a) suitable premises, and

(b) sufficient Sisters and lay staff, and

(c) suitably selected and trained sisters and lay staff to prevent abuse of the children in their care, and

(d) an adequate system of internal inspection, and

(e) an effective system of managerial support and supervision.

27 The Congregation of the Sisters of Nazareth did not take sufficient steps to try to obtain adequate funding for either Termonbacca or Nazareth House.

Findings in respect of the Ministry of Home Affairs and the Department of Health & Social Services

28 The Ministry of Home Affairs and the Department of Health & Social Services failed to:

(a) construct, and

(b) implement an appropriately rigorous inspection regime to ensure that children in St. Joseph's Home, Termonbacca and Nazareth House were safe from abuse.

29 The Ministry of Home Affairs and the Department of Health & Social Services did not take sufficient steps to ensure that St. Joseph's Home, Termonbacca and Nazareth House were required and/or helped to provide:

(a) suitable premises, and

(b) sufficient Sisters and lay staff, and

(c) suitably selected and properly-trained sisters and lay staff to ensure that the children in these homes would be provided with childcare that was:

(i) in accordance with the standards of the time, and

(ii) of the same standard as that received by children in homes in the statutory sector.

Failings by the welfare authorities

30 Neither the county borough welfare committees (or the Western Health & Social Services Board as their statutory successor) as the statutory bodies which placed, or assumed responsibility for, children in care in St. Joseph's Home, Termonbacca or Nazareth House, took adequate steps to monitor the care given to individual children in either home.

31 None of the statutory bodies which placed, or assumed responsibility for, children in either home took adequate steps to monitor the facilities for, and standards of care provided to, children in either home.

32 None of these statutory bodies took adequate steps to inform themselves of the provision made by the Sisters of Nazareth for the care of other children in either home whose circumstances might have brought those children within the responsibility of the statutory bodies concerned.

33 None of those statutory bodies provided adequate financial or administrative support for the children they placed in the care of the Sisters of Nazareth in either home.

Volume 2 – Chapter 6 – Module 2 – Child Migration to Australia

34 This portion of the Inquiry's Report is concerned with its investigations into why and how a number of children from institutions in Northern Ireland were sent to Australia, almost all of whom went in the years after the Second World War. When the Inquiry publicised its existence in Australia in 2013 we received a very large number of applications from people resident in Australia, mostly in Western Australia, and it became obvious that there were two main aspects of their experiences that required investigation: firstly, the allegations of abuse which they say they suffered in residential institutions in Northern Ireland before they went to Australia; and secondly, how and why these children were selected to go to Australia, because many allege that the process was itself abusive.

35 Many applicants were bitterly critical of the institutions for sending them to Australia, and of the Northern Ireland and United Kingdom Governments for permitting and facilitating their being sent to Australia. They also complain of the effect that being sent has had on their lives, not least because they allege they were subjected to serious forms of abuse in the institutions to which they were sent in Australia. In their evidence many described how they lost all contact with their parents and siblings. Although, after many years and much effort, some were able to re-establish some contact with their relatives, for others it was too late, because their parent had died, or, when they were able to trace their parent or family members, the reunions were not successful. Their complaints also extend to other matters, such as not being able to obtain birth certificates, or discovering that their names or dates of birth had been altered, things which created major difficulties for them in later life when they had to prove their identity for official purposes.

36 Many of those who spoke to us in person, or who described their experiences in their written statements, spoke movingly of the profound effect that being sent to Australia as children had upon them. Those who wish to study their accounts in greater detail will find them on the Inquiry website, together with the relevant documents and transcripts, at Days 42 to 50. The words of HIA 324[1] in his statement provide a striking example of the effect upon him of being sent to Australia as a child, views which are representative of the views of many applicants:

> "My life in institutions has had a profound impact on me. I have always wondered what it would be like to have had a family – a mother and father and brothers and sisters. I never got the chance to find out because I was sent to Australia. We were exported to Australia like little baby convicts. It is hard to understand why they did it. I know the theory – to populate Australia. I still cannot get over the fact that I was taken away from a family I never got the chance to know. I was treated like an object, taken from one place to another. I found it very hard to show affection to my children when they were young. I have improved as the years have gone on. I have a nightmare every night of my life. I relive my past and am happy when daylight comes."

37 HIA 324, who was born in 1938, was 75 when he spoke these words to the Inquiry legal team in Perth in 2013. Sadly he died before he was able

1 AUS 10743.

to sign his statement and see the Inquiry consider his account, and the accounts of the other child migrants who have contacted us.

38 It became clear that many questions were raised by what we were told.

- Why were child migrants sent to Australia?
- How many were sent?
- Who sent them?
- Who decided that they would go?
- How were they chosen?
- Were their parents consulted?
- What happened before they were sent?
- How did they get to Australia?
- What happened to them when they got there?
- Were they able to contact their parents or families afterwards?

39 In this part of our Report we examine each of these questions except for "What happened to them when they got there?" We took the view that the institutions remained responsible for any child they sent until the child disembarked in Australia, and so we examined the arrangements that were made for the children travelling to Australia, and the conditions during the voyages to Australia.

40 We made clear at the beginning of the public hearings of the module relating to Australia that our powers do not permit us to investigate the experiences of the applicants in the institutions to which they were sent once they arrived in Australia.[2] However, in order to examine whether the institutions in Northern Ireland took any steps to keep contact with the children, or to inform themselves of the progress of the children, it was necessary for the Inquiry to know what the applicants themselves had to say about these matters. Almost every applicant was very concerned about the difficulties they experienced in later life because of the inadequate information available to them about their origins and families in Northern Ireland. In addition, the applicants themselves had much to say about their experiences in Australia. In order to obtain a complete picture of all these matters, when the Inquiry recorded statements from these applicants we therefore included their accounts of the experiences to which they say they were subjected in various institutions in Australia.

2 Chairman's opening remarks. Day 42, 1 September 2014.

41 Many applicants who gave evidence to us in this module were unable to remember anything, or if they did they often remembered very little of their time in institutions in Northern Ireland. Where they can recall such matters, their evidence is referred to, where necessary, in those parts of our Report which deal with the particular institutions in Northern Ireland. This portion of our Report is solely concerned with the experiences of those who spoke to the Inquiry in relation to how they came to be selected to be sent to Australia, their experiences on the way to Australia, their experiences after they arrived to maintain contact with their relatives in Ireland during their childhood, or in later years, the success or otherwise of these efforts, and the effects on them of being sent to a different country many thousands of miles away as young children.

42 As part of our investigations we sent members of the Inquiry to Australia for approximately a month at a time in September to October 2013, and June to July 2014. On each occasion the team was made up of two members of the Acknowledgement Forum panel, two members of our legal team and two witness support officers. They went to Australia for two reasons. Firstly, to enable those applicants now living in Australia to have the same opportunity to describe their experiences to the Acknowledgement Forum as applicants who live in Northern Ireland and elsewhere. Some of the Australian applicants chose only to describe their experiences to the Acknowledgement Forum and did not wish to engage with the Statutory Inquiry element of the Inquiry's proceedings. The second reason was to enable our legal team to record witness statements from applicants in Australia, as well as to gather a considerable amount of documentary material and other information in relation to the matters which the Inquiry will consider later in this part of the Report.

43 Although the majority of the applicants who had been sent to Australia as children landed in, and still live in, Western Australia, some now live in other parts of Australia. In order to enable as many applicants as possible to speak to the Inquiry team at convenient locations, the Inquiry team saw applicants in Perth in Western Australia, in Brisbane in Queensland, and in Melbourne in New South Wales. Many of the applicants travelled considerable distances to speak to the Inquiry team and we are very grateful to them for doing so.

44 The Inquiry then devoted nine days of public hearings[3] to examining the experiences of those who were sent to Australia. During that time the Inquiry received oral evidence from eleven applicants. Three who were in Northern Ireland at the time were able to give evidence in person at Banbridge Courthouse, and the other eight did so by live TV-link from Australia. A further 38 witnesses gave their evidence in the form of the written statements which they had provided to the Inquiry; these were read out by Counsel to the Inquiry in public. Altogether we received evidence from 52 of the 65 applicants from Australia, because three further witnesses were not called during the Australian module but gave evidence in a later module in respect of their experiences in institutions in Belfast. Their evidence in relation to those institutions is considered in that part of the report that deals with those institutions, but their accounts of experiences relating to their migration to Australia are included in this portion of the Inquiry Report.

45 The remainder of the 65 chose not to speak to the Statutory Inquiry, and those who wished to do so spoke only to the Acknowledgment Forum. Sixty-five applicants represent almost half of all those whom we believe were sent to Australia from Northern Ireland as child migrants, and their evidence enabled us to piece together a detailed picture of many of the procedures involved.

46 The Inquiry received many helpful documents from applicants in Australia that greatly assisted us in our work. The Inquiry also carried out exhaustive searches in the Public Record Office of Northern Ireland (PRONI), as well as receiving evidence from the Sisters of Nazareth and the Health and Social Care Board. We also received helpful information from the Child Migrants Trust (CMT) and from Tuart Place in Australia. Documents we obtained from the National Archives of Australia at the end of the module threw considerable light on the arrangements for child migration to Australia between 1938 and 1950, and this file was subsequently added to the evidence bundle.

47 We wish to place on record our thanks to the Royal Commission, which provided staff to accompany applicants at the locations in Australia from which they were speaking to the Inquiry by live link, thereby enabling us to provide the same level and type of support to witnesses giving evidence as we did for witnesses in Northern Ireland. We are also most grateful

3 Days 42 to 50, from Monday 1 September 2014 until Monday 15 September 2014.

to the Chief Justice of the Family Court of Western Australia, and to his staff, and to the staff of the Family Court of Australia at Melbourne, for their invaluable help in making available their premises and staff to allow applicants to give evidence by live link.

48 The Inquiry was fortunate in securing evidence from Dr Ann Mary McVeigh, of the Public Records Office of Northern Ireland (PRONI), and from Dr Margaret Humphreys OBE, OAM. Dr McVeigh made available to us her thesis on the topic '*History of the Child and Juvenile Migration Schemes to Australia*', for which she was awarded a doctorate by The Queen's University Belfast in 1995. The greater part of the information contained in the portion of the Report relating to the historical background to child migration to Australia is drawn from Dr McVeigh's work, supplemented by her oral evidence.

49 The topic of child migration to Australia is one that has generated a considerable amount of controversy in both the United Kingdom and in Australia for more than 20 years. It was brought to the attention of the wider public by the work of Dr Margaret Humphreys in particular, and by her book *Empty Cradles: One Woman's Fight to Uncover Britain's Most Shameful Secret*, published in 1994. Not only did this provide much important background material for the Inquiry, but Dr Humphreys also prepared a detailed witness statement to which we refer later in this Report. In that statement, and in her oral evidence, she described many of the problems faced by former child migrants in re-establishing contact with their families in Northern Ireland and elsewhere, and the impact of their experiences upon them. These were matters which were also dealt with by applicants in their witness statements.

50 In addition, the Inquiry received a document entitled 'Report on the Impacts and Outcomes of Child Migration Experienced by Former Child Migrants in Northern Ireland', prepared by Dr Philippa White, Director of Tuart Place.[4] The accounts given by many of the witnesses and Dr White's report, taken together with the evidence of Dr Humphreys, provided a great deal of information which we shall consider later. We also received helpful information from Prof. Gordon Lynch, Michael Ramsay Professor of Modern Theology at the University of Kent. Prof. Lynch has made a special study of child migration, and his 2016 book *Remembering Child Migration: Faith, Nation-Building and the Wounds of Charity*[5] deserves to be read by everyone interested in the history of child migration.

4 AUS 6056-6057.
5 Bloomsbury, 2016.

Findings relating to the Northern Ireland Government

51 It was indifferent to the practice of the voluntary sector in Northern Ireland of sending child migrants to Australia.

52 It failed to fully inform itself as to what was happening once it became aware that significant numbers of such young children were being sent to Australia by voluntary organisations such as the Sisters of Nazareth.

53 It failed to make any enquiries whatever as to the fate of these children.

54 It failed to make any representations to the United Kingdom Government about the operation of the child migrant schemes.

55 The Minister of Home Affairs was wrong to approve the proposal by Tyrone County Welfare Committee that HIA 354 should be sent to Australia.

Findings relating to Tyrone County Welfare Committee

56 It was wrong to send HIA 354 to Australia.

57 It failed to give proper weight to the effect of severing contact between HIA 354 and his brother and sister when seeking approval from the Minister.

58 It failed to inform the Minister that HIA 354 had a brother and sister who were also in the care of the Committee.

59 It failed to inform the Minister that the foster parents of HIA 354 wished to adopt him.

Findings relating to the Irish Church Missions and Manor House Home

60 The home was wrong to send children to Australia who were so young.

61 The home failed to take sufficient steps to maintain contact with the children after they went to Australia.

62 The home did not give truthful information to parents of the children who enquired where their child was.

Findings relating to the Sisters of Nazareth

63 They were wrong to send children to Australia who were so young.

64 They failed to make any enquiries to satisfy themselves that the homes run by other Roman Catholic religious orders in Australia were suitable to receive their children.

65 They failed to take sufficient steps to maintain contact with the children after they went to Australia.

66 They did not give truthful information to parents of the children who enquired where their child was.

67 In many cases they did not provide detailed, accurate and timely responses to enquiries by former child migrants for information that would have assisted them to trace their parents and relatives.

Findings in respect of all institutions that sent children to Australia

68 Failing to ensure that those who accompanied the children were competent to look after the children during the voyage.

69 Failing to ensure that a suitable case history was sent with each child to the institution to which the child was being sent.

Volume 3 – Chapters 7, 8 & 9 – Module 4 – Sisters of Nazareth, Belfast

Volume 3 – Chapter 7 – Module 4 - Introduction and common issues

70 In Module 4 we considered two Roman Catholic children's homes, Nazareth House and Nazareth Lodge, which were sited near each other, about one and a half miles south of Belfast city centre. The Module commenced with an introduction by Senior Counsel on 5 January 2015, and continued until 19 May 2015 when there were closing submissions. In all, there were 41 days of hearings allocated to this Module.

71 In total, evidence was received concerning the two homes, either in person or through the reading of their statements, from a total of 117 witnesses who had been in Nazareth House or Nazareth Lodge as children. Of these, (taking account of witnesses who were in both homes) 74 gave oral evidence in this module. Thirty-three other witnesses, such as sisters, houseparents, social workers or inspectors also gave oral evidence. More people spoke to the Inquiry about the Belfast Nazareth homes, therefore, than about any other homes.

72 There were 50 applicants who had been resident in Nazareth House who contributed statements. The evidence of ten of these witnesses was read

out as they were unable to attend for health reasons, and two because the witnesses sadly had died since preparing their statements. Three did not engage further with the Inquiry. One witness had given his evidence about Nazareth House during the module on Rubane. We therefore heard oral evidence from 34 witnesses.

73 We received evidence from 52 former residents of Nazareth Lodge. The statements of five were read out because of the ill health of the applicants, and two because of the deaths of the applicants, again sadly before they could give oral evidence. Five of the witnesses had given their evidence in the Rubane module, so that in this module we received oral evidence from 40 witnesses. In all, 31 of the people who gave evidence to the Inquiry concerning the Belfast Nazareth homes had also been in Rubane, as from 1953 to 1972 the boys in Nazareth Lodge were usually transferred there at the age of eleven. Two of the witnesses were not applicants but were former residents, one of them appearing at the request of the Sisters of Nazareth.

74 A number of children were sent to Australia as child migrants from both homes. Of these, two former residents from Nazareth House and one from Nazareth Lodge gave oral evidence during the module, and have been included in the figures above. There were also ten more applicants from Nazareth House and twelve from Nazareth Lodge who gave evidence during the module concerning Australia. Their evidence is dealt with in Chapter 6. One of these witnesses had been in both homes, and so in total, therefore, 24 child migrants who had been in Nazareth House or Nazareth Lodge gave evidence to the Inquiry. It should be noted that many applicants who gave evidence in other modules provided only limited accounts of their time at Nazareth House or Nazareth Lodge.

75 We received evidence from seven social workers, six middle and senior managers in the social services and five members of the Social Work Advisory Group (SWAG) or Social Services inspectorate (SSI). One teacher, one GP, one chaplain, one handyman, two volunteers, five houseparents and eight sisters provided evidence. Three of these people did not appear due to ill health; the remainder gave both written and oral evidence. The evidence of all but one related to Nazareth Lodge, mainly because Nazareth House closed in 1984 and they provided evidence concerning enquiries into complaints about Nazareth Lodge in the following years. In addition, one sister who gave evidence had moved from one home to the other, and her evidence related to both homes.

76 Submissions were also received from Sister Brenda McCall on behalf of the Sisters of Nazareth, from the HSCB on behalf of the predecessor bodies which had provided social work support for the children and their families, and from Dr Hilary Harrison for the then Department of Health, Social Services and Public Safety.

77 We are indebted to the witnesses, all of whom came to address disturbing and painful personal memories or difficult issues for which their organisations had been responsible. The memories recounted to us typically related to events between forty and eighty years ago, and we have been aware that while the details of some incidents have remained sharp because of their emotional impact at the time, other memories are hazier or may have been influenced by the sharing of accounts or the passage of time. We are aware that for a small number of applicants who came to tell us of their experiences there has been the added shock that other witnesses have accused them of bullying or some form of abuse, and coming to terms with the perceptions of others will have added to their distress.[6]

78 The Congregation emphasised the risk entailed in relying on memories that may be faulty or false. We have been alert to the need to cross-check witnesses' written and oral evidence for consistency with the evidence of others and surviving documentation. As might be expected, we have come across errors and inconsistencies. One witness, for example, thought that as a very young child she had been in Nazareth House, but written records indicated that she had confused the home with another institution; in view of her age at the time and the length of time since her period in care, such confusion is thoroughly understandable.

79 The fact that we have quoted witnesses extensively does not mean that we have accepted their versions of events unquestioningly. We appreciate that some evidence will have been affected by exaggeration or false memories, and the fact that we have not qualified every statement with a clause to state that this is the witness's allegation should not be taken to imply that we accept or reject the particular observation.

80 However, the more witnesses who repeated similar accounts of life in the two homes, and the more substantiating detail they provided, the more persuasive they proved to be. It is not our role to decide precisely what happened in relation to each allegation or to determine the guilt

6 SNB 100007.

of individuals, but to conclude whether on balance there were general systemic failures. The volume and detail of the evidence has been sufficient to provide us with a full picture of what life was like in the two homes and to reach conclusions about the allegations of systemic abuse. It should be noted that, while many witnesses have been quoted in this chapter, on most subjects there were many others who have not been quoted but who provided corroborative evidence.

81 Inevitably, the applicants to the Inquiry have largely been people who had unhappy experiences about which they wished to complain, and drawing together their evidence in this chapter has also been a selective process, primarily identifying the failings of the homes. The picture painted, therefore, is inevitably not a balanced account of life in the homes.

Findings relating to both homes

82 We consider the failure to meet the statutory requirement for both Nazareth House and Nazareth Lodge to be visited monthly to have been a systemic failure.

Volume 3 – Chapter 8 – Module 4 – Nazareth House, Belfast

83 Many of the tasks which the girls were required to perform were of little use to them as preparation for managing their own households, and in our view the excessive chores expected of the girls constituted systemic abuse.

84 The infrequency of changing bath water, the use of carbolic soap to clean teeth, the use of Jeyes fluid in the bath, the rough treatment when bathing and the queuing were outdated institutional practices which should have been superseded or never adopted in the first place, and they constituted systemic abuse.

85 The punitive approaches described in the evidence would not have given the children any sense of security but would have added to their anxiety; the measures would have been ineffective in dealing with enuresis and constituted very poor childcare practice, amounting to systemic abuse.

86 The home nursing described was very poor in terms of the failure to take some problems seriously, the rudimentary treatment given, the physical abuse on some occasions, and the lack of loving care for children who were unwell. This amounted to systemic abuse.

87 There was no valid childcare justification for confiscating the children's personal possessions, and this constituted systemic abuse.

88 During the earlier decades, the combination of aspects of poor childcare (such as excessive chores, an institutional approach to bathing, the use of Jeyes fluid, the handling of menstruation and sex education, the poor quality of food, the insistence on eating unwanted food, the failure to celebrate birthdays, the poor quality of education at the school on the premises and the failure to prepare children for discharge) which were all below the standard which might reasonably have been expected at that time and we consider amounted to systemic abuse.

89 The public corporal punishments inflicted in the 1950s constituted systemic abuse.

90 The range and variety of examples and the number of witnesses, particularly in relation to SR 189, SR 31, SR 134 and SR 116, indicate that the physical abuse practised by the staff was systemic.

91 We conclude that the emotional abuse suffered by some girls was systemic.

92 We consider the lack of inspection amounted to a systemic failing by SWAG to ensure that the home was meeting statutory regulations and providing proper care.

Volume 3 – Chapter 9 – Module 4 – Nazareth Lodge, Belfast

93 By the 1980s the bathing system used at Nazareth Lodge should have been abandoned long before and its continuation represented systemic abuse.

94 When Jeyes fluid was first developed in the late nineteenth century it was used for many purposes, but by the 1950s it should not have been used in baths or for hair washing. This practice was well out of date and in our view its use amounted to systemic abuse.

95 There was no justification for SR 118's cruel conduct in dealing with enuretic boys, which amounted to systemic abuse.

96 We accept that force-feeding took place and it constituted systemic abuse.

97 We consider the Sisters' failure to pass relevant information about a child's time in Nazareth Lodge, even if little was known about their lives before coming into the care of the Sisters of Nazareth, was unacceptable

and showed a lack of care and consideration for each child's individuality, development and well-being which we considered amounted to a systemic failing.

98 Taking account of all the aspects of daily life in the home, for the most part they constituted poor, out of date childcare practice, and we consider this was systemic abuse.

99 The physical abuse by staff, particularly on the part of SR 118, SR 34, NL 4 and NL 5, was so extensive that it created a punitive atmosphere. It was contrary to good childcare practice, the policy of the Order and the statutory Regulations under which the home worked. Furthermore the Sisters failed to apply a system of staff selection, supervision and management to prevent or limit the abuse. This was a case of systemic abuse and systemic failure.

100 The name-calling, denigration of parents, lack of care for sick boys, the emotional impact of physical punishment, and the lack of individual care in these examples all constitute emotional abuse as well as unacceptably poor child care practice, and we consider them to have been systemic abuse.

101 It was the use of charge boys to supervise younger boys in the absence of the sisters which predictably led to the most serious bullying. To rely on the older boys to control the younger ones unsupervised was a systemic failing.

102 In leaving the care and control of the younger boys to the older charge hands, the opportunities for sexual abuse were increased, and this amounted to systemic abuse.

Failings of the DHSS

103 We agree with the conclusion of the Hughes Inquiry that the frequency of inspection was unsatisfactory and consider the lack of inspection of Nazareth Lodge in that period amounted to a systemic failing by SWAG to ensure the home was meeting statutory regulations and providing proper care.

104 It is our view that in this instance the Department failed to accept its overarching responsibility for ensuring that the safety of children in residential care was maintained. We consider that this was a systemic failing.

105 We acknowledge that the Department was breaking new ground in drafting the complaints procedure at this time but we are critical that it included that agencies should undertake internal investigations of complaints and we are critical of the Sisters for conducting the investigation secretively.

Finance

106 We conclude that the shortage of finance and its consequent impact on staffing levels and physical standards of care amounted to a form of neglect and constituted systemic abuse. Although both central government and the welfare authorities bore some responsibility, this was primarily the responsibility of the Sisters of Nazareth.

Volume 3 – Chapter 10 – Module 6 – Father Brendan Smyth

107 John Gerard Smyth joined the Norbertine Order as a novice in 1945, and took the name Brendan, and so he was known as Fr Brendan Smyth for the remainder of his life. He was ordained a priest in 1951 and remained a priest until his death in 1997 while in prison in the Republic of Ireland. Until he was arrested and sentenced in Northern Ireland in 1994 he committed acts of sexual abuse against an unknown number of children in Northern Ireland, in the Republic of Ireland and elsewhere. Although he was convicted of 43 separate offences against 21 children in Northern Ireland for offences committed between 1964 and 1984, and a further 74 separate offences committed against another twenty children in the Republic of Ireland for offences committed there between 1967 and 1993, he admitted on a number of occasions that he did not know how many children he had abused, saying that it could be hundreds.

108 Amongst the 43 offences in Northern Ireland to which he pleaded guilty in 1994 and 1995 and for which he was sentenced to a total of four years imprisonment, three related to children who were in Nazareth House in Belfast, and five related to children in Nazareth Lodge, also in Belfast, both of which were children's homes run by the Sisters of Nazareth. However we accept that he also committed offences against other children, some of whom he also abused in either Nazareth House or Nazareth Lodge. He is also alleged to have abused children in two other children's homes in Northern Ireland. One was the home for boys at Rubane, Kircubbin, Co. Down, run by the De La Salle Order, and the other was the home for girls run by the Sisters of St Louis at Middletown, Co. Armagh.

109 Fr Smyth committed offences against many more children, and in many other places, as well as against children who were in those four children's homes in Northern Ireland. Because our Terms of Reference required us to examine whether there were systemic failings on the part of those responsible for children in residential homes in Northern Ireland, our focus had to be on how he was able to commit offences against children in those homes.

110 As Fr Smyth was able to move around and abuse children for so many years, and because the failings of several organisations and individuals contributed to his ability to abuse children over many years in different places, it was necessary for us to consider whether that abuse could have been stopped in those homes in Northern Ireland. The events surrounding his abuse of children in different places over many years were so inextricably interlinked that it was impossible to isolate what happened in the four homes in Northern Ireland within our Terms of Reference from the wider picture of his offending outside those homes, and the failures to protect children from him.

111 For that reason it was necessary to refer in some detail to allegations of abuse of children by Fr Smyth elsewhere, and to consider the response of various organisations and individuals to those allegations. We were aware that Fr Smyth was alleged to have abused children in schools, in the homes of their parents, on visits to Dublin, and in places as far apart as Wales, Scotland and the United States of America. We had to refer to those allegations in order to see when those organisations and individuals were aware of the threat he posed to boys and girls with whom he came in contact as a priest, and to examine what those organisations or individuals did, or did not do, as a result of this knowledge.

112 It may seem to some of those who were abused by him on those occasions that we should have devoted more attention to those allegations, but were we to examine those other allegations in detail that would have exceeded our Terms of Reference. Nevertheless, by confining our investigation into his activities in this way it should not be thought that we did not appreciate the effect of his activities on those children who do not come within our Terms of Reference, or the implications for organisations or individuals in other countries outside our Terms of Reference.

The Norbertine Order

113 Permitting Fr Smyth's ordination despite a clear warning from the Abbot General that Fr Smyth should not be ordained.

114 Failing to:

(a) properly assess the grave risk Fr Smyth posed to children; and

(b) warn the bishops of the dioceses to which he was sent in later years, namely

- Menevia in Wales
- Annan in the Diocese of Galloway
- Providence, Rhode Island, USA
- Fargo, North Dakota, USA.

115 Taking deliberate decisions to withhold information about Fr Smyth's background when he was sent to other dioceses.

116 Giving advice from the Abbot General that it was not necessary to send that information to other dioceses.

117 Failing to act on credible reports of Fr Smyth's sexual abuse of children.

118 Allowing repeated efforts to be made to 'cure' Fr Smyth by sending him for various forms of medical treatment on several occasions, even though it was clear from continuing complaints that, despite earlier treatments, he was continuing to abuse children.

119 Failing to insist that he provided adequate information as to the nature and extent of his treatment, and the prognosis, from the various doctors who treated him.

120 Deciding not to withdraw his access to a car, thereby enabling Fr Smyth to travel freely and abuse children in many homes and locations in both Northern Ireland and the Republic, even after he had been charged by the police in 1991.

121 Failing to confine Fr Smyth to the Abbey in Kilnacrott and thereby keep him away from children.

122 Failing to report Fr Smyth to the police and social services in either Northern Ireland or the Republic of Ireland, thereby preventing him from being prosecuted and convicted, and so enabling him to continue his abuse.

123 Failing to have in place adequate procedures:

(a) to prevent Fr Smyth being ordained;

(b) to have Fr Smyth reported to higher authority in the Order, and to the Congregation of Religious and for Secular Institutes in Rome when the members of the Order received definite information that he was committing crimes against children.

124 Failing to notify the bishops of the Diocese of Down and Connor and the Diocese of Kilmore of the dangers Fr Smyth posed to children in their dioceses when he was known, or suspected, to be going to these dioceses.

125 Failing to vigorously pursue the existing procedures and to notify the Congregation of Religious and for Secular Institutes of Fr Smyth's crimes.

The Roman Catholic Diocese of Kilmore

126 Failing to notify the police and social services in the Republic of Ireland when the 1973 complaint was received, and failing to institute ecclesiastical proceedings against Fr Smyth at that time.

127 Failing to have Brendan Boland's father in the room with the child whilst the child was being questioned; and in the case of FBS 39 failing to notify his parents of the alleged abuse, or to have his parents present during questioning. In both cases there was also a failure to follow up with the parents of each child how the child was reacting to the abuse afterwards.

128 Failing to take all the steps open to the diocese to thoroughly investigate each allegation relating to Fr Smyth that came to its notice and to report the matter to the proper civil and ecclesiastical authorities on each occasion.

129 Failing to inform the civil and ecclesiastical authorities in Belfast about what had, or may have happened, to the two named children from Belfast.

130 Failing to report the allegations relating to Fr Smyth to the Congregation of Religious and for Secular Institutes.

131 Failing to exercise sufficient pressure on Abbot Smith to take vigorous action against Fr Smyth, such as laicisation or restricting his freedom of movement.

132 Failing to use the existing process properly by short-circuiting matters and proceeding directly to investigate Fr Smyth instead of referring the matter to the Archdiocese of Armagh.

133 Failing to ensure that all Fr Smyth's ecclesiastical faculties were permanently withdrawn.

134 When the faculties were renewed from year to year, failing to take proper steps to ensure that Fr Smyth was not still offending.

135 Failing to warn other dioceses, and in particular the Diocese of Down and Connor, about the allegations so that they could take steps to protect the children in homes in their diocese from being abused by Fr Smyth.

The Roman Catholic Diocese of Down and Connor

136 Failing to disseminate to other bishops and institutions the concerns known to the Diocese about, and later the knowledge of, the sexual abuse alleged against Fr Smyth.

137 Failing to report the allegations against Fr Smyth to the social services and the police in Northern Ireland when they were received by the Diocese.

138 Failing to institute a penal investigation or process against Fr Smyth in the Diocese of Down and Connor on the basis of the allegations of his abuse in that Diocese.

139 Failing to exert greater pressure upon Abbot Smith in 1971, by (1) asking for urgent and immediate information, and for that to be confirmed; (2) threatening to institute the church inquiry process in Down and Connor against Fr Smyth as had been done in Kilmore by Bishop McKiernan.

The Sisters of Nazareth

140 The failures of SR 31 and SR 46 to report the complaints made to them about Fr Smyth to the mother superior.

The De La Salle Order

141 Failing to notify the police and social services in Northern Ireland of the allegations against Fr Smyth made to BR 1.

Volume 4 – Chapter 11 – Module 3 – Rubane House, Kircubbin

142 The Inquiry devoted Module 3 to the examination of evidence relating to Rubane House (Rubane), a home run by The Institute of the Brothers of Christian Schools, a Roman Catholic male religious order, on behalf of

the Roman Catholic Diocese of Down and Connor. The Institute of the Brothers of Christian Schools has always been best known throughout Ireland as the De La Salle Order and it will be referred to as 'the Order' in this chapter of the report.

143 The Inquiry devoted 30 sitting days spread over eight sitting weeks to this module, commencing on 29 September 2014 and finishing on 17 December 2014. Fifty-seven former residents of Rubane applied to give evidence to the Statutory Inquiry and we heard oral evidence from 47 of them. The witness statements of six applicants were read to the Panel during Module 3: four were read because they were unable to attend for medical reasons;[7] and, sadly, two because the applicants died before they could give oral evidence.[8]

144 The statements of two witnesses were also read because they had previously given evidence in person in Module 1, which dealt with the Sisters of Nazareth homes in Derry/Londonderry, and had only brief comments to make about their time in Rubane.[9]

145 We also heard evidence in Module 3 from two former residents of Rubane put forward as witnesses by the Order.[10] A statement from another witness[11] put forward by the Order was submitted towards the end of the module; we took this statement into account but did not consider it necessary to ask him for the evidence to be given in person.

146 The statement of one witness[12] was discounted because he failed to attend to give evidence and provided no reason for his lack of attendance.

147 The evidence of four witnesses was heard in Module 4,[13] which dealt with the Sisters of Nazareth homes in Belfast, as these applicants had only brief comments to make about their time in Rubane. Three gave their evidence in person and the statement of the fourth was read because he was unable to attend for medical reasons.

148 Therefore, in total, the Inquiry had the benefit of receiving evidence from 60 former residents of Rubane. Twelve of these former residents were admitted to Rubane in the 1950s, 26 in the 1960s, seventeen in the 1970s and five in the 1980s.

7 HIA16, HIA 160, HIA 262 and HIA 388.
8 HIA 159 and HIA 427.
9 HIA 381 and HIA 382.
10 DL 40 and DL 455.
11 DL 244.
12 HIA 260.
13 HIA 89, HIA 368, HIA 210 and NL 122/DL 208.

149 The Order provided written responses to each witness statement and we took these responses into account. We also received written statements from nine current and former brothers of the Order[14] who lived and worked in Rubane and received oral evidence from five of these brothers.[15] BR 2 gave evidence on two occasions; on the first he responded to allegations made against him and on the second, as a former brother director of Rubane, he provided more general information about how the home operated and was managed.

150 Brother Pius McCarthy, the Provincial Secretary to the Order in Ireland from 1974 to 1976 and from 1995 until his death in May 2014 provided witness statements and helpful background material to the Inquiry. The current Irish Provincial, Brother Francis Manning, also provided written statements and gave evidence in person on behalf of the Order.

151 Four former members of lay staff who worked at Rubane[16] gave evidence in person to the Inquiry. The Inquiry was only able to locate one former member of lay staff, DL 11, towards the end of the module. We accepted there were good reasons why he could not attend in person at short notice and took his written statement into account.

152 The Inquiry also considered statements from the Department of Health, Social Services and Public Safety (DHSSPS) as the successor department to the Ministry of Home Affairs (MoHA) and the Department of Health and Social Services (DHSS), each of which had statutory responsibility for the registration and regulation of Rubane as a children's home. We heard oral evidence from Dr Hilary Harrison on behalf of the DHSSPS and from a former employee of the Social Work Advisory Group[17] who was involved in the regulation of Rubane.

153 The Health & Social Care Board (HSCB), as the successor to the various local or statutory authorities which had responsibilities for the care of children placed in Rubane, provided written evidence including statements from fifteen current and former social workers who had experience of Rubane, as well as from Valerie Watt, the current Chief Executive of the HSCB. We considered these statements and asked for, and received, oral evidence from five of these individuals.[18]

14 BR 2, BR 3, BR 7, BR 10, BR 25, BR 29, BR 33, BR 62 and BR 77.
15 BR 2, BR 7, BR 10, BR 29 and BR 77.
16 DL 1, DL 81, DL 509 and DL 149.
17 DL 521.
18 DL 503, DL 515, Mr Bunting, DL 516 and DL 517.

154 Father Timothy Bartlett, Episcopal Vicar for Education and Director of Public Affairs for the Diocese of Down and Connor, provided statements and gave evidence in person on behalf of the Diocese.

155 We also considered documentation relating to police investigations and civil claims against the Order that identified 158 former residents of Rubane who did not apply to the Inquiry but who alleged similar types of physical and sexual abuse as that alleged by witnesses to the Inquiry. Counsel to the Inquiry brought relevant information from these investigations and civil proceedings to the attention of the Panel during the public hearings. Rubane was considered by the Committee of Inquiry into Children's Homes and Hostels chaired by His Honour Judge William Hughes (The Hughes Inquiry) and we considered the findings of that Inquiry in relation to Rubane.

156 We also considered written and oral closing submissions from the De la Salle Order, the DHSSPS, the HSCB and eight individuals[19] against whom allegations of abuse were made. In total, we considered almost 40,000 pages of documentation in this module, 20,000 pages of which were provided by the police.

Findings relating to the Ministry of Home Affairs

157 It failed to insist from the outset that Rubane be developed on the smaller children's home model in line with government policy.

158 It contributed to a systemic failure to ensure Rubane provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to continue for a decade while over-crowding increased and the facilities and staffing levels became more inadequate and unsatisfactory.

159 It failed as the registering body to clarify with the Diocese and the Order the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care.

160 It failed to ensure Rubane provided proper care by allowing the number of boys accommodated to more than double from 30 to 71 within six years without requiring the necessary improvements to the facilities or increases in staffing levels.

19 BR 2, BR 3, BR 10, BR 25, BR 62, BR 77, HIA 21 and HIA 147.

161 It failed to seek confirmation of who was the administering authority for Rubane and failed to check that monthly visiting was happening and thereby allowed crucial aspects of the statutory framework designed to promote and protect the welfare of children in voluntary homes to be ignored by the Diocese and the Order.

The Department of Health & Social Services

162 It failed to inspect the standard of care being provided in Rubane between 1976 and 1981.

163 It failed to ensure that the inspections of Rubane that were carried out in the 1970s gained a genuine insight into the quality of care being provided.

164 It failed to properly respond to the concerns raised by the EHSSB in 1981 about the general care provided to all boys in Rubane and thereby failed to acknowledge and exercise its statutory authority and powers as the registration and inspection body for Rubane

165 It failed to maintain information about an investigation into sexual abuse in a children's home in a manner that allowed its existence to be known to relevant staff and thereby shared with the Hughes Inquiry.

The Roman Catholic Diocese of Down and Connor

166 It contributed to a systemic failure to ensure Rubane provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to continue for a decade while overcrowding increased and the facilities and staffing levels became more inadequate and unsatisfactory.

167 It failed to clarify with the Order and the MoHA as the registering body the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care.

168 It failed to meet statutory regulations for voluntary children's home, in particular it failed to confirm the administering authority for Rubane and to appoint a monthly visitor.

169 It failed to take responsibility for negotiations with the MoHA about the development of the home and by only holding annual meetings of the governing board during the Order's negotiations with the MoHA caused delay and late interventions in planning.

170 It failed to hold meetings of the governing board between 1968 and 1972 and between 1982 and 1985 and thereby to assure itself of the quality of care being provided in Rubane.

171 It failed, through the chaplains appointed to Rubane, to find a means that respected the seal of confession but enabled information provided by boys about the physical and sexual abuse they were suffering to be shared with the relevant bishop and acted upon.

172 It failed through Father McCann's response to the first assault by BR 77 to take all proper steps to prevent, detect and disclose abuse.

Findings relating to the De La Salle Order

173 It contributed to a systemic failure to ensure Rubane provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to continue for a decade while overcrowding increased and the facilities and staffing levels became more inadequate and unsatisfactory.

174 It failed to clarify with the Diocese and the MoHA as the registering body the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care.

175 It failed to meet statutory regulations for voluntary children's home, in particular it failed to confirm the administering authority for Rubane and to appoint a monthly visitor.

176 It failed to prevent excessive physical punishment by some brothers and lay staff.

177 It failed to prevent random violence by some brothers and lay staff which in some cases amounted to serious physical assault.

178 It failed to ensure that corporal punishment was administered in line with statutory regulations and the Order's own rules.

179 It failed to accurately record and report the use of corporal punishment as required by statutory regulations.

180 It failed to deal adequately with incidents of physical violence by brothers and lay staff towards boys which were brought to the attention of Brother Directors.

181 It failed to take necessary action to enable the investigation and prosecution of criminal offences involving physical abuse.

182 It failed to inform the Department or the Health and Social Services Boards about the search of Rubane and the reasons for it and therefore did not work with them to identify and manage any continuing risk to the welfare and safety of the boys in Rubane at that time.

183 It failed to report serious assaults by BR 77 to the police in order to protect the brother and the reputation of the Order rather than protect vulnerable children.

184 It failed to curtail BR 77's contact with children while he was subject to police investigations about physical assaults of boys in Rubane and instead moved him to work in a school.

185 It failed to provide guidance and effective supervision to brothers and to ensure, particularly in the earlier years, that they had a reasonable workload that avoided excessive contact time with the boys.

186 It failed to provide guidance and effective supervision to lay staff in Rubane, particularly to those who were clearly having difficulties in meeting the challenges of working with adolescent boys.

187 It failed to address understaffing, thereby allowing a lack of oversight of the brothers' interactions with boys, particularly in the evenings and at night time, that enabled sexual abuse to occur and continue unchecked.

188 It failed to properly investigate allegations of sexual abuse.

189 It failed to take necessary action to enable the investigation and prosecution of criminal offences involving sexual abuse.

190 It failed to report its investigation of the allegations of sexual abuse against BR 17 to the governing board, the MoHA or the police.

191 It failed to be truthful about the extent of BR 14's sexual abuse of boys and deliberately misled the MoHA about it.

192 It failed to report its investigation of the allegations of sexual abuse by HIA 36 against BR 15 to the governing board, the MoHA or the police.

193 It failed to implement and monitor adherence to its rules about how brothers should manage their interactions with boys and thereby betrayed the implicit trust that other bodies such as the MoHA, the welfare authorities

and the Diocese placed in the Order as a faith-based organisation suitable to be entrusted to run a residential home for children.

194 It failed to curtail the activities of BR 17 or increase monitoring of him despite suspicions that he sexually abused boys in Rubane and then moved him to a school where he would have continued trusted access to children which he ultimately abused.

195 It failed to report brothers who admitted sexual abuse of children to the police and thereby protected the position of such brothers and the reputation of the Order rather than seeking to prevent further harm to children.

196 It failed to keep boys free from the pain, fear and distress caused by the physical and/or sexual abuse they suffered or witnessed others suffering in Rubane.

197 It failed to limit the boys' help with potato-picking to the farm in Rubane and instead required them to pick potatoes and undertake other types of labour in neighbouring farms in adverse weather and with inappropriate clothing.

198 It failed to ensure initially that all boys in Rubane were adequately clothed and in later years up to 1981 failed to ensure that all boys were appropriately clothed.

199 It failed to require the Sisters of Nazareth to provide relevant information about at least a child's time in Nazareth Lodge when they were being transferred to Rubane and thereby demonstrated a lack of care and consideration for each child's individuality, development and well being.

Findings in respect of Welfare Authorities

200 In the period prior to the opening of chalets in 1968 they failed to address the fact that the home they were placing boys in had inadequate facilities and was poorly staffed.

201 The EHSSB failed to alert social workers to the police investigations in 1980 into physical and sexual abuse in Rubane.

Volume 4 — Chapter 12 — Module 7 — St Patrick's Training School

202 The seventh Module concerned four training schools, the first being St Patrick's, a Roman Catholic school run by the De la Salle Order. The Module commenced on 1 September 2015, Day 134 of the Inquiry, with a general introduction to the training school system by Senior Counsel, followed by an address by Junior Counsel concerning St Patrick's, and it ended on 14 October 2015, Day 150.

203 A total of 27 applicants provided statements which related to St Patrick's. Of these, eleven were read out for various reasons. Two had sadly died, some had given evidence in a previous module about another home, so their observations on St Patrick's had been provided earlier, and some were unwell. One witness who had provided a statement decided not to give oral evidence after consultation with counsel on the day. Four former residents at St Patrick's also gave evidence, while not being applicants. In all, we therefore received oral evidence during the Module from 19 witnesses who had been resident in the training school. A further 39 former residents had given information to the police about allegations or had made civil claims, so that evidence was considered from a total of 70 people who had attended St Patrick's.

204 Seven brothers and seven other members of staff gave oral evidence. One witness who had inspected St Patrick's gave evidence. Mary Madden, who had worked for the Northern Ireland Office in the final years of our remit when the NIO bore responsibility for the training schools, and Karen Pearson, who represented the Department of Justice and the then Department of Health and Social Services and Public Safety, gave evidence. The Diocese of Down and Connor, the De la Salle Order and the Health and Social Care Board were also represented as core participants.

205 We are indebted to all these witnesses for providing their accounts of events at St Patrick's. We are aware that recalling difficult times and presenting evidence in a public hearing will have been stressful for many witnesses, but both the written and oral evidence was invaluable in providing a full picture.

Findings

206 The failure of St Patrick's to conform to the Training School Rules in respect of secure accommodation, and of the Inspectorate to note the breaches and take action, constituted systemic abuse.

207 The use of informal corporal punishment was systemic abuse.

208 Permitting older boys to punish others when supervising them in the dormitory was a breach of the Training School Rules and was systemic abuse.

209 The humiliation of stripping a boy naked to stand in full view on a number of occasions constituted systemic abuse.

210 The failure to report the abductions of Bernard and Gerard Teggart to the Police was clearly a systemic shortcoming on the part of the Brother Director. The failure of the Board of Management to meet immediately after the boy's death, to investigate and to provide support to the staff and boys was negligent and constituted systemic abuse.

211 There is nothing to suggest that the NIO took any steps following the death of Bernard Teggart to investigate whether any policies or procedures needed to be changed to protect boys from suffering a similar fate, and their failure to do so represents a systemic failing on their part.

212 Statistical returns concerning absconding were provided by St Patrick's to the NIO and these records would have been open to Inspectors when they visited. Prior to the concern raised by the death of SPT 81 neither the NIO nor the SSI had raised absconding as a major issue with St Patrick's and this was a systemic failure on their part.

213 The failure to circulate the findings of the report on absconding from Rathgael more widely and assist St Patrick's in finding ways of dealing with persistent absconding was a systemic failure on the part of the NIO.

214 Furthermore, the APRU, which had been set up as a combined unit to support all the training schools and which had undertaken the research on absconding, also failed to share their findings with St Patrick's, when they must have known that it had a similar problem.

215 The failure of St Patrick's to take adequate measures to counter absconding constituted systemic abuse, in that it left boys vulnerable in terms of the risks they faced when absconding, in the patterns of criminality which were fostered while absconding, and in the effect of their absconding pattern on their later lives.

216 We consider that the frequency with which the secure rooms were used and their use for young children, contrary to the Training School Rules, amounted to systemic abuse on the part of St Patrick's and by the SSI in failing to address this breach of the Rules.

217 The failure to appoint sufficient staff amounts to systemic failure.

218 We consider it to be a systemic failure that St Patrick's was not inspected between 1971 and 1988, and we consider the lack of formal inspections a systemic failing.

219 The sexual abuse perpetrated by the Brothers, particularly as reported in the television room, was systemic.

220 BR 1 sexually abused boys while he was at St Patrick's and this constituted systemic abuse; if he had been apprehended and had not been promoted to be Brother Director of Rubane House, the boys there would not have been abused by him.

221 Bishop Farquhar was at fault in failing to suspend BR 26 during the police enquiries, and St Patrick's was at fault in undertaking their own limited investigation. These failures were systemic, potentially putting the boys then and subsequently at St Patrick's at risk.

222 The failure of the Brother Director:

(i) to inform both the police and his Committee of the allegations of abuse by DL 137 in 1978 and again in 1980,

(ii) to dismiss DL 137, permitting him to resign,

(iii) to protect potential victims of sexual abuse in providing DL 137 with a positive job reference which omitted the reason for his departure from St Patrick's were systemic failures.

223 The prevalence of unauthorised physical punishment in the 1960s and early 1970s was contrary to the Training School Rules, and constituted systemic abuse.

224 It was a systemic failure that potential whistle-blowers felt unable to speak up.

Volume 5 – Chapter 13 – Module 7 – Introduction

225 In Module 4 we considered Nazareth Lodge, which was an industrial school until 1950. In Module 7 we heard witnesses from St Patrick's, which was an industrial school and reformatory until 1950, when it became a training

school. In the same Module we also considered Rathgael, a training school which admitted both boys and girls, a few of the witnesses having also been in Malone or Whiteabbey, Rathgael's predecessors. We also heard from applicants who had been in Lisnevin, a secure training school, and Hydebank, a young offenders' centre. In Module 10, witnesses who had been in Millisle, a borstal, gave evidence. In Module 11 we heard from applicants who had been in St Joseph's, which was the only training school specifically for girls which we considered.

Volume 5 – Chapter 14 – Module 7 – Rathgael Training School

226 Rathgael was registered as a training school for boys in 1968, but its role was rooted in the earlier history of the reformatory and industrial school system in Northern Ireland, and in particular Balmoral Industrial School, Malone Reformatory and Whiteabbey, a school for girls.[20]

Findings

227 RG 17's practice of using frequent unrecorded informal corporal punishment was unacceptable and amounted to systemic abuse.

228 NIO's failure to ensure that Rathgael was inspected from 1973 to 1987 was a systemic failing.

229 The extent of the unregulated physical punishment applied by some staff amounted to systemic abuse.

230 The failure to prevent bullying by peers amounted to systemic abuse.

231 The lack of training in control and restraint was a systemic failing.

232 RG 47's sexual exploitation of HIA 236, his failure to raise concerns about HIA 236's crush with colleagues and their failure to question the relationship properly all constituted systemic abuse.

233 A small number of staff sexually abused girls during this phase and this amounted to systemic abuse.

20 For a fuller history of Rathgael and its predecessor institutions, see RGL 22202-22246. We are indebted to Campbell Whyte and Lindsay Conway for much of the information describing the running of Rathgael.

Volume 5 – Chapter 15 – Module 7 – Lisnevin Training School

234 We considered evidence about Lisnevin Training School (Lisnevin) during Module 7, which dealt with juvenile justice institutions. Module 7 commenced on 1 September 2015 and concluded on 24 November 2015. Twelve applicants referred in their written statements to time they spent in Lisnevin. Two of these applicants, HIA 320 and HIA 50, referred to spending periods in Lisnevin but made no further comment about their time in the school.

235 The evidence of HIA 418 and the responses to it were summarized as HIA 418 could not attend in person for medical reasons. We set aside the evidence of HIA 275 and did not take it into account as he did not appear to give evidence in person and gave no reason for not doing so. We heard evidence in person from the remaining eight applicants.

236 Dr Bill Lockhart OBE, a chartered forensic psychologist, provided psychological services in Lisnevin from 1973 until 1983 as part of the Adolescent Psychology Research Unit (APRU). Dr Lockhart provided a detailed statement with exhibits about Lisnevin[21] and gave evidence in person. We also received a statement[22] and evidence in person from LN 25 who worked as a care worker and then manager in Lisnevin. LN 8, a former teacher in Lisnevin, provided a written statement.[23]

237 We considered response statements to the evidence of applicants and contemporaneous documentation to support these statements provided by the Department of Justice (DoJ) and the Health and Social Care Board (HSCB).

238 We were assisted by a joint statement submitted by the DoJ and the Department of Health, Social Services and Public Safety (DHSSPS), which provided background information about the establishment and operation of Lisnevin.[24] The DoJ also provided a helpful and detailed closing submission responding to the evidence given about Lisnevin during Module 7.[25]

21 LSN 1227-1250.
22 LSN 1224-1226.
23 LSN 872- 874.
24 LSN 925 -957.
25 RGL 90160–90187.

239 We were also assisted by a written statement and exhibits from Alan Shannon CB,[26] a retired civil servant who held senior policy and operation responsibility for training schools from 1990 to 1992 and a statement from his successor Mary Madden CBE, who held that responsibility from 1992 to 1995[27] and who gave evidence in person during our consideration of St Patrick's Training School.

240 Dennis O'Brien was appointed deputy headmaster at Lisnevin when it first opened. Later in his career he was appointed as an inspector with the Social Services Inspectorate (SSI) and in that role he was a member of the team who undertook the first SSI inspection of Lisnevin in 1988. Mr O'Brien provided a statement which we also took into account.[28]

Findings

241 The lack of schooling from September 1981 to May 1982 amounted to a systemic failing by the Lisnevin Management Board, the NIO and the Department of Education to ensure the institution provided proper care.

242 The failure of the director to refer allegations of the assault of a boy by staff to the RUC amounted to a systemic failing to take all proper steps to prevent, detect and disclose abuse.

243 The delay in providing adequate training for staff in control and restraint methods amounted to a systemic failing by the Management Board and the NIO to ensure the institution provided proper care.

244 Accommodating boys in bedrooms with limited furnishing and making them store their clothes in the corridor outside their bedroom amounted to a systemic failing by the Management Board and the NIO to ensure the institution provided proper care.

245 The use of a tariff system of standard sanctions, and the associated reduction in managerial involvement and oversight of use of separation, amounted to a systemic failing by the Management Board and the NIO to ensure the school provided proper care.

246 The failure to address inadequate staffing levels which were clearly having an impact on the daily experience and care of the boys amounted to a systemic failing by the Management Board and the NIO to ensure the school provided proper care.

26 LSN 254-675.
27 LSN 676-760.
28 LSN 875-877.

247 The lack of inspection of Lisnevin from when it opened in October 1973 until the first inspection by the SSI in April 1988 was a systemic failing by the NIO to ensure that the school was providing proper care.

248 The leave arrangements during the summer months, which led to a dependence on casual staff, was a systemic failing by senior managers to ensure the school provided proper care.

Volume 5 – Chapter 16 – Module 7 – Hydebank Wood Young Offenders Centre

249 During Module 7 we heard evidence from four witnesses who were admitted to Hydebank Wood Young Offenders Centre (Hydebank) during the period 1983 to 1990. HIA 275 referred to his time in Hydebank in his statement but we left his evidence out of account as he failed to appear to give evidence in person or to provide a reason for not doing so.

250 We also heard from Maxwell Murray who commenced work as the deputy governor of Hydebank on October 1984 and remained there until April 1987. He acted as governor of the facility for most of the last two years he worked there. Mr Murray provided a very full and helpful statement to the Inquiry and appended exhibits of relevant documentation, for example guidance provided to officers about what type of clothing inmates should be allowed to wear,[29] and how they should report incidents and occurrences.[30] His statement and exhibits amounted to 1,202 pages. We are grateful for the detailed background information Mr Murray provided about how Hydebank operated in the period he worked there and for his responses to the evidence witnesses gave about their time in Hydebank. We also received a helpful statement and exhibits about the use of control and restraint techniques in Hydebank from Mr David Dowds of the Northern Ireland Prison Service.

251 We were assisted by a joint statement for this module provided by the Department of Justice (DoJ) and the Department of Health and Social Services and Public Safety (DHSSPS) and a closing submission provided by the DoJ. We considered response statements to the evidence of witnesses from the DoJ, the Health and Social Care Board (HSCB) and from a former prison officer, HB 4, who responded to specific allegations made against him.

29 HYD 1469.
30 HYD 1311.

Findings

252 On admission to Hydebank boys experienced a strict regime, and the repetitive cleaning tasks and requirement to maintain their cells to a strict high standard were aimed at ensuring inmates conformed to the discipline of Hydebank and the authority of officers. It is probable that some officers took the approach of intimidating boys at the committal stage in order to enforce obedience and discourage any resistance to the regime.

253 Hydebank was a prison and was dealing with some boys who had been found unmanageable in open training schools, and a firm approach was necessary in order to maintain discipline. Despite that imperative, the evidence of Mr Murray and that provided through inspection reports and reports of the visiting committee indicated that a progressive regime was operated that allowed boys to gain privileges and to move purposefully towards release. That evidence also indicated that there was a range of educational, vocational and training activities available to the inmates.

254 The witnesses we heard from had negative experiences in Hydebank and did not consider their time there in a positive light. However, having carefully considered the evidence provided to us, we decided that the complaints we received did not amount to evidence of systemic abuse in Hydebank.

Volume 5 – Chapter 17 – Module 10 – Millisle Borstal

255 Woburn House, as it was officially known, was a borstal for males aged sixteen to twenty-one from 1956 to 1980, but it was usually known as Millisle Borstal. It was designed to provide training for work, education and leisure activities for young offenders who were unsuited to training schools and who would otherwise have been sent to prison.

256 The Inquiry addressed the allegations of ten applicants in Module 10, which commenced with an introduction by Junior Counsel on 18 January 2016. Seven applicants were heard in person and two statements were read out on the grounds of the ill health of the applicants, HIA 262 and HIA 320. The statement of one further witness, HIA 294, was based on the account he gave to the Acknowledgement Forum, as he had hoped to give evidence in person but was sadly deceased before he was able to prepare a witness statement. Evidence was heard from three former officers and one former governor (Duncan McLaughlan), as well as Stephen Davis on behalf of the Department of Justice. Evidence for the Module was completed on 26 January 2016.

257 We wish to express our appreciation for the help provided by the witnesses concerning their experiences as trainees at Millisle, nearly all of whom had already given evidence in relation to other residential institutions. We are aware that recalling such memories can be a painful process. We are grateful to all those in the Department of Justice who identified relevant records and contributed to the statements for the Inquiry presented by Stephen Davis, the Director of Operations for the Northern Ireland Prison Service (NIPS). We are indebted to the officers who were employed at Millisle for providing first-hand recollections, and in particular to Duncan McLaughlan who was Governor during the period covered by most of the allegations.

258 Nearly all the evidence was provided by the Department of Justice, but some records, such as Prison Service personnel details, were not available, presumably as a result of destruction of files considered to be no longer required. In particular, there was a review of records at Millisle in May 1977 at which it was noted that there were 'dead' files for over a thousand trainees and these were presumably destroyed.[31] There are therefore some gaps in our knowledge. Unlike other institutions investigated by the Inquiry there were no social services files concerning the trainees during their time in Millisle as there were no social workers actively involved with them then. There was also very little police documentation, as (with one exception) the witnesses had not complained to the police and their allegations had not been investigated previously.[32]

259 We accept that there was on occasion low-level violence in the closed unit between 1977 and 1980. This was contrary to Governor McLaughlan's instructions and may have reflected working practices introduced by prison officers from other prisons in the early months of the closed section, but it was unacceptable and constituted systemic abuse. It is our further conclusion that on occasion low-level physical abuse was also reported in the open borstal, and that this was also systemic abuse.

260 We consider Officer Skillen's behaviour to have been systemically abusive.

261 We also consider it a systemic failure that at times information about Officer Skillen and his misconduct failed to reach senior officers who could have taken action, and that when it did reach them, as reported in the evidence, they failed to take action.

31 MIL 141, 143.
32 MIL 106-107.

262 The Prison Service complaints system whereby trainees could address complaints to the Governor, the Visiting Committee or the Department was undermined by the pressures exerted by prison officers and rendered largely ineffective, and we consider this to have been a systemic failure.

263 The emotional impact of the training methods in the closed unit and the emotional damage associated with physical abuse constituted systemic abuse.

264 The night staffing was insufficient to prevent peer abuse, and the failure to protect trainees was systemic.

Volume 5 – Chapter 18 – Module 11 – St Joseph's Training School

265 In Module 11 we considered evidence about St Joseph's Training School (St Joseph's) which was run by a Roman Catholic congregation, the Sisters of St Louis. Module 11 commenced on 8 February 2016 and concluded on 22 February 2016. We received evidence from sixteen former residents of the school, five of whom gave evidence in person during Module 11: HIA 203; HIA 178; HIA 161; HIA 198; and HIA 376.

266 The statements of two former residents, HIA 249 and HIA 176, were summarised and read out during Module 11 because they were unable for medical reasons to give evidence in person. We also took into account statements from three former residents of St Joseph's who wanted to tell us about their positive memories of the care they received in the school: SJM 73; SJM 74; and SJM 75.

267 Two former residents, HIA 49 (Day 9) and HIA 233 (Day 16) gave evidence in person about their time in St Joseph's during Module 1, which dealt with children's homes in Londonderry run by the Sisters of Nazareth. Four other former residents - HIA 124 (Day 96), HIA 195 (Day 101), HIA 175 (Day 100), and HIA 84 (Day 109) - gave evidence in person about their time in St Joseph's during Module 4, which dealt with children's homes in Belfast run by the Sisters of Nazareth.

268 During Module 11 we heard evidence in person from four nuns who worked in St Joseph's: SR 235, SR 234, SR 247 and Sister Canice Durkan. We considered helpful statements from SR 240 who was the Director of St Joseph's for almost thirty years from 1972 to 2000. Unfortunately SR 240 was unable for medical reasons to give evidence in person. We also

considered a statement from SR 254. In addition to these statements the Sisters of St Louis provided written responses to the statements of former residents and related contemporaneous documentation.

269 A former member of lay staff of St Joseph's, SJM 4, provided a statement in response to allegations made against her and a written closing submission. SJM 56, who was HIA 176's social worker when she was in St Joseph's, provided a statement about his work with HIA 176.

270 We were assisted in developing our understanding of the establishment and operation of St Joseph's by the access we were given to extensive records relating to the school, which were maintained and retained by the Sisters of St Louis. These included daily logs, visitors' books, punishment books, the minutes of meetings of the Board of Management and quarterly returns about the use of corporal punishment, which were submitted to the Ministry of Home Affairs (MoHA). We were also assisted by police material and civil claim papers in relation to St Joseph's.

271 The Department of Justice (DoJ) provided a general statement about St Joseph's and written responses to the statements provided by former residents. However, it was unable to provide detailed responses to the statements of applicant witnesses born before 1957 as its records for residents of St Joseph's only extend back to those born after that year. The Department of Health, Social Services and Public Safety (DHSSPS) provided witness statements about the inspection and regulation of St Joseph's.

272 The Health and Social Care Board (HSCB) provided a general statement about St Joseph's and written responses and background documentation about the involvement that any of its predecessor bodies had in the care of applicant witnesses.

273 The Sisters of St Louis, the DoJ, HSCB and the DHSSPS also provided written closing submissions. We are grateful for the evidence all witnesses provided for this module and the assistance it gave us in considering whether there were systemic failings in the care provided in St. Joseph's.

Failings by the Ministry of Home Affairs and the Northern Ireland Office

274 The lack of formal inspections in the period from 1968 to 1987 was a systemic failing by the MoHA, and then the NIO, to ensure that St Joseph's

was providing proper care and meeting statutory requirements about the operation of training schools. This meant that girls in the school at that time did not have the benefit of external monitoring of the facilities and practices in the school.

Failings by the Sisters of St Louis

275 During the period of SR 237's directorship, between 1957 and 1971, she was physically abusive to girls to the extent that it amounted to systemic physical abuse.

Volume 6 – Chapter 19 – Module 8 – Barnardo's

276 The Inquiry devoted Module 8 to the examination of evidence relating to two homes run by the organisation now known as Barnardo's, but for most of that time as Dr Barnardo's, in Northern Ireland. These homes were known as Macedon and Sharonmore, and were dealt with in the same module because Sharonmore succeeded Macedon, and many of the applicants, and much of the evidence, related to a period when some of the applicants were in one or other of the two homes. Some at least of the issues and the evidence relating to these issues overlapped both homes.

277 The Inquiry devoted two weeks covering eight sitting days between 7 December 2015 and 17 December 2015, during which we heard oral evidence from three applicants and received the written statement from a fourth. We also received oral and written evidence from Lynda Wilson, the Director of Barnardo's Northern Ireland, and from five former employees of Barnardo's. The Inquiry tried unsuccessfully to locate BAR 2, but on 17 December 2015 he made contact with the Inquiry. He was then provided with the relevant evidence, and ultimately provided the Inquiry with a statement dated 24 February 2016. He was offered the opportunity to give oral evidence but declined to do so.[33]

278 We had written submissions from a number of those who were the subject of allegations, as well as submissions on behalf of Barnardo's, the Department of Health, Social Services and Public Safety (DHSSPS) as the successor department to the Ministry of Home Affairs (MOHA), and the Department of Health and Social Services (DHSS), which had statutory responsibility for these homes during the period with which we

33 BAR 2546-2548.

are concerned. We also received written submissions on behalf of the Health and Social Care Board (HSCB), as the successor to the various local or statutory authorities which had responsibilities for the care of children they placed in Barnardo's.

Findings of systemic failings by Barnardo's in relation to Macedon

279 The failure to detect the bizarre behaviour of BAR 3, and then to take appropriate action, were systemic failures because they demonstrated a lack of knowledge of what was happening among the staff on the part of management at Macedon.

280 We consider the amount of unsupervised access by BAR 4 to HIA 216, and the failure of Barnardo's to inform the EHSSB that this access was taking place, represented systemic failures by Barnardo's to provide proper childcare.

281 There were systemic failings in the way in which the allegations about BAR 3 were handled by Barnardo's staff at Macedon.

(1) They were not reported for some months by BAR 8 to BAR 24.

(2) A deliberate decision was made by BAR 24 not to report the full facts to his superiors or to anyone else.

(3) BAR 75 does not seem to have reported the remark made to him by BAR 47 that BAR 3 was a "real fruity boy" to his superiors at Barnardo's.[34]

282 The reluctance on the part of some Barnardo's staff in Northern Ireland in the 1980s to report allegations about staff to the proper authorities was a systemic failing.

283 The manner in which the relationship between HIA 516 and BAR 12 was allowed to develop, and the length of time for which it was allowed to continue, represented systemic failures by Barnardo's to ensure proper childcare of HIA 516.

284 The 'wooden spoon' episode, and the way it was ultimately dealt with, represented a number of systemic failings on the part of Barnardo's.

- The three staff who struck HIA 101 acted in breach of Barnardo's policy of no corporal punishment.

34 BAR 8619.

- That each resorted to the use of a spoon in such an impulsive fashion suggests this may well have not been the only occasion that staff resorted to a wooden spoon to administer minor corporal punishment.
- To admonish the three staff, and to place a note on each of their personal files, was an inadequate and inappropriate response. The proper course to have taken at that time would have been for each to have received a formal written warning.

285 The way in which BAR 1 was allowed to frighten children with ghost stories and the 'evil eye' practice, and that it went unreported and/or undiscovered for several years, represented a sysytemic failure by Barnardo's staff to exercise proper supervision.

286 BAR 1's bathing of male children who were of an age when they should have been left completely to bath themselves was an unacceptable practice which should not have been allowed to occur. That it was allowed was due to inadequate supervision of BAR 1 by management at Macedon, and amounted to a systemic failing.

287 BAR 1 had shown herself to be a completely unsatisfactory employee to be placed in the care of children for a considerable period of time before she finally resigned and Barnardo's failure to terminate her employment at an earlier stage represented a systemic failing to ensure that suitable staff were in place to look after the children in Barnardo's care.

288 We agree that the failure of Barnardo's management to investigate the nature of Mains's connection with BAR 1 and Macedon represented a systemic failing on the part of Barnardo's.

289 The failure to prevent the relationship between BAR 2 and BAR 47 developing, and then to put a stop to it, represented a systemic failing on the part of the management at Macedon to ensure proper standards of professional behaviour on the part of BAR 2.

290 There was poor management at, and of, Macedon during BAR 1's employment.

291 There was a failure on the part of the management at Macedon to ensure proper standards of professional behaviour on the part of BAR 2.

Systemic failings by SWAG

292 The failure to carry out inspections of Macedon in the 1970s.

Volume 6 – Chapter 20 – Module 9 – Manor House

293 The Inquiry devoted Module 9 to the examination of Manor House Home (Manor House), a children's home in Lisburn, County Antrim. Manor House was run by The Society for the Irish Church Missions to the Roman Catholics, which was a mission agency associated with the Church of Ireland. The organisation is now known as the Irish Church Missions (ICM) which is a registered charity concerned with the encouragement of Gospel growth in Ireland.

294 The Inquiry devoted four sitting days to this module commencing on 5 January 2016 and finishing on 8 January 2016. We received complaints about Manor House from six former residents. We heard evidence from two of these witnesses, HIA 346 and HIA 341, on 4 September 2014, as part of Module 2 of the Inquiry which dealt with child migrant schemes. During Module 9 we heard three witnesses, HIA 365, HIA 290 and HIA 366, and a summary of the statement of HIA 289 who was unable to attend in person for health reasons.

295 HIA 354, who gave evidence on 3 September 2014, during Module 2 of the Inquiry, referred to a brief stay he had in Manor House in November 1950 prior to being sent to Australia. HIA 354's only memories of Manor House were of being taught hymns and being given a bath and new clothes prior to his departure to Australia. He had no complaints about how he was treated in the home.[35]

296 In addition to the evidence from witnesses, we considered information provided by the ICM about the establishment and operation of Manor House and its written responses to the statements provided by witnesses about the home. Reverend Edmund Coulter, the current Superintendent of ICM and Reverend Courtney, a retired Church of Ireland clergyman, gave evidence in person. Dr Hilary Harrison provided a written statement and gave evidence in person on behalf of the Department of Health, Social Services and Public Safety (DHSSPS). Fionnuala McAndrew, Director of Social Care and Children's Services, Health and Social Care Board, provided a statement and exhibits on behalf of the Health and Social Care Board (HSCB), and the HSCB also provided written responses to the statements from former resident witnesses.

35 MNH 033/4.

297 We also examined police material about investigations into allegations of peer sexual abuse in Manor House, sexual abuse of a resident by an adult visitor to the home and sexual abuse of another resident by a man unconnected to the home.

298 We spent some time considering the initial funding and inspection of the home by the Ministry of Home Affairs (MoHA). This was because the MoHA's engagement with Manor House provided the only example we are aware of where the MoHA contemplated removing registration granted to a voluntary children's home under the Children and Young Persons Act (Northern Ireland) 1968.

Findings of systemic failings by the ICM

299 The irresponsible approach by the General Committee of the ICM to re-open Manor House as a children's home amounted to a systemic failing to ensure the home provided proper care.

300 The general state of dilapidation of Manor House in 1953, the inadequate sleeping, toilet and washing facilities for the children, the poor heating and the low staffing levels amounted to a systemic failing by the Management Committee to ensure the home provided proper care.

301 The harsh response by staff in the 1940s and 1950s to children who suffered from enuresis, including segregating these children and making them sleep in unacceptable conditions amounted to a systemic failing to ensure the home provided proper care.

302 The Management Committee's delay in appointing an officer in charge during the period August 1963 to June 1965 and its failure to appoint a monthly visitor amounted to a systemic failing to meet statutory requirements and ensure the home provided proper care.

303 The Management Committee's failure in the early 1970s to engage directly with the MoHA to find out more about and address Miss Forrest's criticisms of the home amounted to a systemic failing on its part to ensure the home provided proper care.

304 In relation to the sexual abuse of HIA 365, HIA 290 and HIA 289 by a male visitor to the home there was a systemic failing on the part of the staff to take proper steps to prevent, detect and disclose abuse.

305 The extent of sexual activity between boys in the home in the period 1975 to 1977 indicates a lack of supervision of children particularly at night

time which amounted to a systemic failure by staff to take all proper steps to prevent, detect and disclose peer sexual abuse in the home.

306 The lack of investigation of the claim by MH 25 that MH 39 had sexually interfered with another girl in the home as well as her amounted to a systemic failing by staff to take all proper steps to prevent, detect and disclose abuse.

307 The lack of supervision that allowed MH 23 to be sexually active from an early age with girls and boys in Manor House amounted to a systemic failing by staff to prevent, detect and disclose abuse in the home.

308 MH 9's decision with Assistant Principal Social Worker MH 73's in 1980 that an informal approach should be used to deal with a member of staff hitting a child with a stick amounted to a systemic failing to ensure the home provided proper care.

The Ministry of Home Affairs and the DHSS

309 The lack of inspection of Manor House for a period of over two and a half years following the initial registration of it as a children's home amounted to a systemic failing to ensure the home provided proper care.

310 The failure to ensure that an officer in charge was appointed during the period August 1963 to June 1965 and arrangements were in place for monthly visiting amounted to a systemic failing to implement statutory requirements and ensure the home provided proper care.

311 The low level of formal inspections of the home in the 1960s, and the MoHA's failure to raise Miss Forrest's criticisms of the home in the early 1970s with the Management Committee, amounted to a systemic failing by the MoHA to ensure the home was providing proper care.

312 The continuing lack of formal inspections in the 1970s when the SWAG took over responsibility for inspection of children's homes on behalf of the DHSS was unacceptable and amounted to a systemic failing by the DHSS to ensure the home was providing proper care.

The SHSSB

313 Assistant Principal Social Worker MH 73's agreement with MH 9 in 1980 that an informal approach should be used to deal with a member of staff who hit a child in the care of the SHSSB with a stick amounted to a systemic failing by the SHSSB to ensure the home provided proper care.

Volume 6 – Chapter 21 – Module 12 – Good Shepherd Sisters

314 As the Chairman explained on 4 November 2015, and again in his opening remarks at the start of this module on 7 February 2016, in this module the Inquiry investigated only those allegations made to it in relation to institutions in Northern Ireland run by the Roman Catholic female religious order The Congregation of Our Lady of Charity of the Good Shepherd (also known as the Good Shepherd Sisters) by those witnesses who were under the age of eighteen when they were placed in one of these institutions. This was because only children in residential care who were under the age of eighteen are within our Terms of Reference. For convenience in this chapter we refer to the Congregation as the 'Good Shepherd' or the 'Good Shepherd Sisters'.

315 The Inquiry investigated allegations relating to Good Shepherd institutions at three locations in Belfast, Derry and Newry. Because of the small number of applicants to the Inquiry who were in each institution, and because some of them were in more than one of the institutions, we decided to investigate all three in the same module. Module 12 started on Monday 7 March, 2016 and the public hearings extended over seven working days, finishing on Tuesday 15 March, 2016.

316 Although there were a number of references by witnesses to their experiences, or the experiences of others, when working in laundries in the three institutions we have investigated, the Inquiry has not engaged in a wider investigation into what are commonly called Magdalene homes or laundries, or mother and baby homes. Because such institutions contained adults over the age of eighteen, and as our Terms of Reference confine us to examining residential homes or institutions for children under eighteen, the experiences of people in such institutions who were over eighteen are outside our Terms of Reference. Whether their experiences should be investigated is a matter for the Northern Ireland Executive and the Northern Ireland Assembly.

317 During Module 12 we heard from nine applicants, seven in person and two whose written statements were read out because they were unable to attend due to poor health. We also received two statements from individuals who came forward to offer favourable accounts of their time as children when they were looked after by the Good Shepherd Sisters in these three institutions.

318 We heard evidence from five Good Shepherd sisters who served in one or more of the three homes at various times, and from Sr Ethna McDermott on behalf of the Congregation. We received witness statements and substantial quantities of material from the Good Shepherd Sisters, from the HSCB, and a small amount of material from the PSNI. We also received a witness statement from Dr Hilary Harrison on behalf of the Department of Heath, Social Services & Public Safety.

319 We concluded that there were the following systemic failings on the part of The Congregation of the Good Shepherd Sisters.

The Good Shepherd Sisters

320 It was unacceptable for young girls under the age of eighteen to be expected to do industrial work in the Good Shepherd laundries.

321 Permitting girls to be asked by a priest whether each was a virgin was a systemic failing.

322 The practices of reading out misdemeanours in front of others and making the offender kneel, or making an offender stand to eat her meal was a systemic failing.

323 By accepting children under school-leaving age, such as HIA 107 and her companions, on a long-term basis the Good Shepherd Sisters failed to ensure that proper care was provided for these children.

324 The failure of SWAG to carry out inspections of each of the three Good Shepherd Sisters Homes was a systemic failing.

325 The failure of each of the three Good Shepherd Sisters Homes to put in place a system of monthly visitors was a systemic failing.

The Ministry of Home Affairs

326 Failing to take steps to prevent children under school-leaving age, such as HIA 107 and her companions, being in the Good Shepherd on a long-term basis.

The Ministry of Home Affairs and/or the DHSS

327 Failing to detect the absence of a system of monthly visitors was a systemic failing on the part of the Ministry of Home Affairs and the Social Work Advisory Group.

Volume 6 – Chapter 22 – Module 15 – Bawnmore Boy's Home

328 Although Bawnmore Boys' Home was examined as part of Module 15 of the Inquiry because a number of those who were resident there were later moved to Kincora Boys' Hostel, we considered that Bawnmore should be dealt with in a separate chapter of our Report. Bawnmore is not to be confused with another children's home of the same name in South Belfast. The Bawnmore in this chapter was the home at Mill Road, Newtownabbey, County Antrim, which existed between 1952 and 1977.

329 The evidence relating to Bawnmore was considered on Days 208, 209 and 210, during which we heard evidence in person from four applicants: HIA 112, HIA 532, HIA 199 and HIA 409. We considered the evidence of HIA 83 who gave evidence at an earlier stage of the Inquiry, and we considered it unnecessary to ask him to give evidence again. We also received evidence from two former members of staff: BM 4 gave evidence in person, whilst BM 13 provided the Inquiry with a written statement.

330 We received a witness statement from Fionnula McAndrew on behalf of the Health and Social Care Board, as the successor to the Belfast Welfare Authority and the Northern Health and Social Services Board (NHSSB), which took over Bawnmore with the reorganisation of local government in 1973 and ran it until it closed in 1977. We also received a witness statement from Dr Hilary Harrison on behalf of what was at that time the Department of Health and Social Services and Public Safety (DHSSPS) and is now the Department of Health, and from Richard Pengelly, who is Permanent Secretary of the same department.

331 Bawnmore was one of the houses investigated by the Hughes Inquiry because of offences involving the abuse of children at the home. The offences came to light during the wider Caskey Phase One investigation by the RUC, which had been set up following the publication of the article in the Irish Independent of 24 January 1980 to which we refer in greater detail in the chapters relating to Kincora. The Caskey Phase One investigation was not simply confined to Kincora; it covered a number of children's homes or hostels, including Bawnmore. As a result of that investigation the police uncovered allegations against five men, two of whom (Peter Bone and Robert Elder) were prosecuted, pleaded guilty and were sentenced by Lord Lowry, Lord Chief Justice, on 16 December 1981 for offences relating to Bawnmore, at the same time that Mains, Semple

and McGrath were sentenced for offences related to Kincora, and Eric Witchell was sentenced for offences relating to Williamson House.

Belfast Welfare Authority

332 The failure to vet Peter Bone amounted to a systemic failing by the Belfast Welfare Authority.

333 The failure of BM 1 to report the abuse of HIA 532 by Bone to his seniors.

334 In relation to the allegations made against Elder by HIA 532 to BM 3.

- BM 3 did not make a written record of the allegations, or of Elder's response.
- BM 3 did not investigate the allegation about the photographs made by HIA 532 against Elder by asking to see them as he should have done.
- BM 3 did not report the matter to his superiors as he ought to have done.

335 The number of boys who were subjected to sexual abuse by staff members.

336 The failure of the Welfare Committee to fulfil its statutory duty to carry out inspections.

337 The failure by SWAG to carry out inspections.

Volume 7 – Chapter 23 – Module 5 – Fort James Children's Home and Harberton House Assessment Centre

338 The Inquiry devoted Module 5 to the examination of particular aspects of the operation of two children's homes in Londonderry: Fort James Children's Home and Harberton House Assessment Centre. Both these homes were managed by the Western Health and Social Services Board (WHSSB), now succeeded by the Western Health and Social Care Trust (WHSCT). Our focused consideration of these homes was prompted by evidence we received from former residents and by police material about investigations they carried out in relation to the homes.

339 Two former residents of Fort James, HIA 108 and HIA 60, and one former resident of Harberton House, HIA 233, raised issues about the care they received in these homes as part of the evidence they gave during Module 1 of the Inquiry, which considered children's homes run by the Sisters of Nazareth in Londonderry.

340 The material we received from the police concerned their investigations into an allegation that FJ 5, the officer in charge of Fort James from September 1980 to August 1983, sexually abused a male resident in the home, and into incidents of peer sexual abuse in Harberton House in 1989-1990, 1992 and 1994.

341 The Inquiry devoted eight sitting days spread over two weeks to this module, commencing on 8 June 2015 and finishing on 18 June 2015. HIA 108's evidence about her time in Fort James in 1980 and HIA 233's evidence about her time in Harberton House in 1991-1992, and responses to their evidence, were heard in Module 1. Therefore, HIA 108 and HIA 233 were not required to go through the pressure of giving evidence in person again in Module 5. Transcripts of relevant parts of the evidence they gave in person in Module 1, and responses to it, were considered during Module 5. HIA 60's evidence about his time in Fort James in 1980-1981 was not heard when he gave evidence in person in Module 1 and therefore he did attend and gave evidence during Module 5.

342 In addition to the evidence from these former residents, we heard evidence from staff who worked in the homes, HH 5, FJ 33, HH 22 and FJ 7, and from senior managers responsible for the operation of the homes, Dominic Burke and Gabriel Carey. Dr Kevin McCoy, Dennis O'Brien and Marion Reynolds gave evidence about the inspection and regulation of the homes and Dr Hilary Harrison gave evidence on behalf of the Department of Health, Social Services and Public Safety (DHSSPS).[36]

343 We also considered written statements from previous senior WHSSB managers such as Thomas Frawley, who was the Area General Manager of the WHSSB from 1984 to 1995,[37] and from the current Director of Women and Children's Services and Executive Director of Social Work of the WHSCT, Kieran Downey.[38]

344 We found that the WHSSB's failure to:

(1) effectively address strategic issues in relation to the provision of residential childcare and lack of foster care, which were clearly having an adverse effect on the appropriateness and level of care that could be given to children in Fort James;

36 FJH 60077-60081.
37 FJH 599-770.
38 FJH 771-791 and 838 -859.

(2) address the excessive overtime worked by staff, in particular FJ 5 the officer in charge, and the implications such work patterns would have for the quality and safety of the care provided to children in Fort James; and

(3) question the appropriateness of FJ 5's close relationship with FJ 30 and respond seriously to comments from children in the home about that relationship and about FJ 5 and FJ 30's sexuality all amount to systemic failings by it to ensure Fort James provided proper care.

The Social Services Inspectorate

345 We found that the SSI on behalf of the Department failed to engage with the WHSSB to support it to consider how best to implement the recommendations of the Bunting Review, although it was aware adverse conditions were continuing to affect the care that children were receiving in Harberton House, and that this failing amounted to a systemic failing to ensure Harberton House provided proper care.

The WHSSB

346 We found that the WHSSB failed in its strategic planning of Harberton House to ensure that complementary services were in place that would allow its remit as an assessment centre to be realised and protected so that it could assess the needs of children and make arrangements for them to receive planned care appropriate to their assessed needs.

347 The WHSSB failed to instigate a fundamental review of its childcare services despite the findings of the Bunting Review and failed to increase its scrutiny of its children's homes in response to Ms McGowan's concerns.

348 These failings amount to systemic failings by the WHSSB to ensure Harberton House provided proper care.

Volume 7 – Chapter 24 – Module 13 – Lissue Hospital

349 Lissue Hospital was unique among the institutions considered by the Inquiry in that it was the only hospital to be investigated, and its functions therefore included medical and nursing care. It is not the Inquiry's role to evaluate the medical care provided, and if there remain medical issues which require investigation the task will need to be allocated to another inquiry to be undertaken by professionals with the appropriate qualifications and experience.

350 However, much of the work of Lissue concerned the residential care of children who were displaying behaviour or conduct disorders, and who might well have been cared for in other types of children's home or residential school if they had been available. Furthermore, most of the allegations made by witnesses were concerned with aspects of childcare, which is within our remit.

351 Module 13 commenced on 4 April 2016 with an introduction by Senior Counsel and we heard the evidence of ten witnesses who had been patients at Lissue Hospital as children. Sadly, one had died, and his evidence was therefore read out. Three former staff gave evidence concerning their respective roles in the multidisciplinary team - three nurses, Moira Mannion, LS 7 and LS 21, two consultant psychiatrists (Dr William Nelson and Dr Roger McAuley), and LS 80, a social worker. On behalf of the core participants Dr Hilary Harrison spoke for the Department of Health, Social Services and Public Safety, (since renamed the Department of Health) and a joint statement was presented by Dr Carolyn Harper and Mary Hinds for the Public Health Agency and Fionnula McAndrew for the Health and Social Care Board (HSCB). Since the closure of Lissue there have been twelve inquiries and reports based on investigations of issues related to the Hospital's functioning. Although undertaken following the end of the Inquiry's remit, their contents have a bearing on our findings, and the chapter therefore concludes with a summary of their contents. After nine days of hearings, the Module closed on 27 April.

352 The governance structure of the hospital from 1973 onwards was a systemic failure, and it is fortunate that it did not engender serious management problems.

353 The successes of the psychiatric unit at Lissue were thanks to cooperation between the individual professionals involved; the managerial structure within which they worked was faulty and systemically unsound.

354 We considered the absence of both formal and informal inspections of Lissue Hospital on a regular basis to have been a systemic failure on the part of the Ministry of Health and Local Government and the Northern Ireland Hospital Authority from 1948 to 1973, and on the part of the Ministry / Department of Health and Social Services and the Eastern Health and Social Services Board from 1973 to 1989.

355 While we cannot say what the outcome of a disciplinary inquiry might have been, we consider the failure of the Eastern Health and Social Services

Board to conduct its own investigations into the allegations of sexual abuse against LS 21 in 1993 to have been a systemic failure.

356 In view of the risk to the children who climbed on the roof at Lissue and the danger which they caused to other people, the lack of action to prevent access to the roof was a systemic failure.

357 The occasions on which physical restraints were used may have been few, but their use was unacceptable; they would not have been used in other types of residential childcare, and their use in a hospital cannot be justified.

358 While the policy was not at fault, the implementation of 'time out' at times was not always in accordance with the policy and constituted systemic abuse.

359 On the occasions when children were sedated to render the nursing task easier, the use of injections constituted systemic abuse.

360 At times some staff did overstep the mark and were unduly rough in their treatment of the children, and that this constituted systemic abuse.

361 We accept that some patients were sexually abused and consider this to have been systemic abuse.

362 There were many instances when staff were unfeeling and failed the children who required their support, and that these shortcomings were sufficiently frequent to be deemed systemic emotional abuse.

363 Any further inquiry into Lissue would be subject to diminishing returns; the additional information which might be gained could well be very limited and it would not justify the time and expense entailed.

Volume 8 – Chapter 25 – Module 15 – Kincora Boys' Hostel

364 Chapter 25 takes the form of an introduction setting the scene for Chapters 26, 27, 28 and 29. In Chapter 25 we briefly described the history of the Hostel, the nature of the allegations which resulted in the prosecution and convictions of Mains, Semple and McGrath; the various police investigations; the Hughes Inquiry; the continuing allegations; as well as explaining the arrangements made to enable this Inquiry to examine the allegations relating to the government departments and agencies which have not been devolved to the Northern Ireland Assembly and Executive

and so lay outside the original Terms of Reference of the Inquiry, and the approach of the Inquiry to all these matters.

Volume 8 — Chapter 26 – Module 15 — The Nature and Extent of the Sexual Abuse of Adolescent Boys Resident in Kincora

The number of residents of Kincora known to have been sexually abused

365 Kincora opened in 1958 and closed in 1980. During that time 309 boys resided in the hostel. In their investigation in 1980 the RUC took 1963 as the starting point for their investigation. Of the 245 boys who resided in Kincora between 1963 and 1980, 104 (42% of the total) were traced and interviewed by the police. We now know that 38 boys were abused at some point during Kincora's existence. Although not all the surviving former residents could be traced, or have since come forward, it can be seen from these figures that the great majority of those who were traced were not sexually abused during their time in Kincora.

366 Indeed the great majority of residents of Kincora who were interviewed by the police were unaware at the time of what was happening in the hostel, and were very surprised to learn of the allegations that emerged afterwards. For example, of 92 former residents of Kincora between 1966 and 1980, 76 (that is 88.33%) told the police they were surprised by the allegations of the extent of sexual abuse that took place during their time in Kincora, even though some of them described how they themselves were abused, or had engaged in homosexual activity with others, whether with McGrath or other residents.

Awareness of abuse

367 It may seem strange that so many of those who were in and out of Kincora in various capacities, not just the residents but the domestic staff and visitors, were unaware of what was happening, but there was a consistent pattern of concealment of their behaviour by Mains, Semple and McGrath.

368 They approached boys who were vulnerable, or who they thought might be easily intimidated. If their initial approaches were firmly rebuffed they generally did not approach that person again. If they did, they went to considerable lengths to approach the boy when others were not around.

369 During McGrath's time at Kincora he appears to have often worked in the evenings and in the mornings, when Mains or Semple was not about, because the duties involving the supervision of the residents were distributed between all three. Mains had other administrative duties as well, and our impression was that more of the direct supervision of the residents in the 1970s was carried out by Semple or McGrath, and because of the way their duties were arranged McGrath was often on duty on his own.

The knowledge by Mains, Semple and McGrath of each other's sexuality

370 Whilst Mains and Semple knew each other before Semple was appointed as deputy warden, and Mains definitely knew of Semple's sexual abuse of residents before Semple was reappointed, there is no evidence either knew McGrath before he was appointed.

371 The evidence suggests that by the time McGrath was appointed Mains had stopped sexually abusing residents, and was engaged in a long-term homosexual relationship with an ex-resident. Semple did not engage in sexual abuse of residents after he was reappointed, and found outlets for his sexual urges elsewhere. This meant that McGrath was the only member of staff who abused residents between his appointment in the summer of 1971 until the home was closed in 1980.

Volume 8 – Chapter 26 – Module 15 – Belfast Welfare Authority, the Eastern Health and Social Services Board, the RUC, The Ministry of Home Affairs and the DHSS

Failings by Belfast Welfare Authority

372 Kincora was never adequately staffed, and this meant that for significant periods only one member of the care staff was on duty in the building.

373 Kincora was a hostel for boys who had reached school-leaving age, but too many children were admitted to Kincora when they were under school leaving age. These children were too young to be placed in such an environment, and too many of them spent too long in that environment when they were admitted.

374 In addition, there were insufficient staff with appropriate training or experience to deal with such young children.

375 Understaffing also meant that staff had to work very long hours, particularly in the case of Mains during the early years, when he was the only member of the care staff for a very long period of time. This meant that he was effectively expected to be on duty all the time. This was very poor practice, and the long hours and low pay put significant pressure on staff, and meant that recruitment of suitable staff was very difficult.

376 The insufficient levels of staff provided Mains, Semple and McGrath with opportunities which they exploited to target their victims when no one else was about to see what was happening, or to suspect what was happening.

377 The way the adolescent boys in Kincora were looked after meant that far too much was done for them by the domestic staff. We consider this created an attitude of dependence by the boys on the staff, and this dependency was exacerbated by inadequate preparation of the residents for independent living when they left Kincora.

The Ministry of Home Affairs and the DHSS

378 The Ministry of Home Affairs, and then the DHSS, failed to maintain an adequate inspection regime of the hostel.

The handling of complaints by the Belfast Welfare Authority and the EHSSB

379 When complaints were made by residents, first of all to the Belfast Welfare Authority, and later to the EHSSB, these were not properly dealt with. In 1967, when the first complaints were received, Mr Mason decided that Mains's conduct did not amount to a prima facie indication of wrong doing. We consider that he was wrong to do so. The Town Clerk's Department was wrong not to implement Mr Mason's recommendations that clear procedures were not put in place to ensure that any further complaints about Kincora were properly reported to the City Welfare Officer. Written and clear instructions should have been given to relevant managers for the closer supervision of Kincora in the future.

380 Again in 1971 the Town Clerk and Town Solicitor did not report the allegations to the police as they should have done. Following the decision not to report the allegations to the police, the following steps ought to have been taken.

a. It should have been re-emphasised to Mains that he should avoid doing anything that could lead to allegations of impropriety.

b. Instructions should have been given that a very close eye was to be kept on both Mains and Kincora.

c. Procedures were not put in place to ensure further allegations about Kincora were properly collated and then referred to the City Welfare Officer, or to his deputy, for immediate attention.

381 After 1971 and throughout the remainder of the 1970s, anonymous phone calls and rumours that appear to have circulated about Kincora amongst staff and other social workers were not made known to senior staff in the EHSSB as they ought to have been.

382 When the RUC told the EHSSB in 1976 of the allegations against McGrath, the EHSSB did not give clear written instructions to ensure that there would be increased supervision of Kincora, of Mains and of McGrath, and staff did not pass to the EHSSB management important information about allegations against McGrath. EHSSB management did not take sufficient steps to press the RUC to find out what was happening with the RUC investigation.

The RUC Cullen/Meharg Investigation

383 In 1974 when the RUC became aware of the allegations made by Roy Garland against McGrath, about which he reminded them in 1976, the Cullen/Meharg investigation was inept, inadequate and far from thorough. The response in 1974 by D/Supt Graham to what he was told by Valerie Shaw about McGrath was wholly inadequate.

384 It was not simply the case that over these years there were a small number of missed opportunities by the Belfast Welfare Authority, by the EHSSB and by the RUC. There were so many failings by all of these agencies that they amount to a catalogue of failures by each. Had the 1971 allegations been reported to the RUC, as they should have been, or if an effective investigation had been carried out by the RUC in later years, it is reasonable to infer that a thorough and competent investigation by trained detectives may have been successful in exposing the abuse in 1976, and possibly even in 1974. This would have meant that those who were sexually abused after 1976, and possibly after 1974, would have been spared their experiences.

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385 We are satisfied that the RUC Special Branch first learnt of William McGrath in July 1966 when he was reported as present as one of the platform party at a rally led by the Reverend Ian Paisley in the Ulster Hall in Belfast. McGrath was otherwise an unknown figure. In 1971 MI5 learnt that a man named McGrath was reported to be the OC of Tara. However, despite efforts to establish who this person was, and gathering much information about him that was inaccurate, it was not until April 1973, 20 months later, that RUC Special Branch identified the Commanding Officer of Tara as the William McGrath seen on the platform in 1966. It seems that it was not until November 1973 that MI5 learned that the OC of Tara and McGrath were one and the same person, probably as the result of a letter sent to MI5 in November 1973 by RUC Special Branch.

386 The security agencies soon concluded that Tara was not a significant force, and they only paid intermittent attention to it and to McGrath in succeeding years.

387 By May 1973 both RUC Special Branch and other RUC officers knew that McGrath was reputed to be homosexual, but they had no proof of this. It was not until Roy Garland spoke to Detective Constable Cullen on 1 March 1974 that the RUC received an allegation that McGrath had engaged in homosexual conduct of a grooming nature in the past with Roy Garland when Roy Garland was a teenager. For understandable reasons Roy Garland was not prepared to come forward to give evidence at that time, and the result was that the RUC had a witness who would not appear in court and who was describing events involving homosexual acts that had occurred a considerable number of years before.

388 Although in 1973 the RUC Special Branch were aware of the allegation that McGrath was homosexual from what appears to have been another source, they did not pass the information relating to the other source to their RUC colleagues as they should have done. Had Special Branch passed on that information then their RUC colleagues, whether in CID or in uniform departments, could have added it to the information that they had already received from the anonymous Robophone message.

389 Despite Roy Garland's commendable efforts to alert Social Services and the RUC to the risk he accurately identified that McGrath might be taking advantage of his position in Kincora to sexually assault residents there, just

as he had sexually assaulted Roy Garland when a teenager, Roy Garland's efforts to do so were unsuccessful through no fault of his own.

390 Although the RUC, MI5, SIS and Army Intelligence were all aware of allegations that McGrath was homosexual, such allegations were common at the time against various political and other figures. In the absence of positive evidence of homosexual acts there was little that could be done by these agencies because no one other than Roy Garland had come forward with a definite allegation that would allow the matter to be pursued.

391 We are satisfied that it was not until 1980 that the RUC Special Branch, MI5, the SIS and Army Intelligence became aware that McGrath had been sexually abusing residents at Kincora, and they learnt of that when it became the subject of public allegations and a police investigation was launched. All four agencies, whilst aware that McGrath was alleged to be homosexual, had no proof of that. They were aware that he worked in a boys' hostel where he was in a position of authority. They were aware of allegations that he had abused Roy Garland a long time before McGrath went to work in Kincora.

392 However, by November 1973, MI5, unlike the other three agencies, were also aware that the person who had by then been identified as William McGrath had been accused of "assaulting small boys". By virtue of Section 5 (1) of the Criminal Law Act (Northern Ireland) 1967, MI5 officers were subject to the same legal obligation as everyone else in Northern Ireland to report the commission of an "arrestable offence" (that is an offence punishable by five years imprisonment) to the police where they knew or believed that such an offence, or some other arrestable offence, had been committed. An alleged assault on small boys could, depending on the nature of the alleged assault, have been an arrestable offence which ought to have been reported to the police.

393 With the benefit of hindsight, and in the light of what is now known about McGrath's abuse of residents in Kincora, it might be argued it was the duty of MI5 to bring to the attention of RUC Special Branch that MI5 had received a report that McGrath had been accused of assaulting small boys, and that by not doing so the MI5 officers who had this information were in breach of that duty. However, we consider that to take that view would be unjustified for several reasons. First of all, although the information was known to MI5 because it had been received eighteen months before, eighteen months separated the receipt of that information

and the information confirming the identity of William McGrath as the leader of Tara. Secondly, the information came to MI5 in a letter from James Miller who was simply reporting what an unidentified source said at a time when unsubstantiated allegations of discreditable behaviour by Tara members about each other were commonplace, and the report was therefore assessed as being of dubious reliability. Thirdly, the MI5 officers were concentrating on establishing what sort of organisation Tara was, and whether it could be a possible Loyalist terrorist group in the context of the extremely volatile political and security circumstances of that time. In all of those circumstances we do not criticise them for failing to appreciate the significance of this information.

394 We consider that had this information been passed to the RUC Special Branch, and by it to their CID and uniformed colleagues, that information may still not have made a significant difference to the approach of the RUC. The RUC had received, and was to receive, much more detailed allegations from the Robophone message, from Valerie Shaw's conversation with D/Supt Graham, and from Roy Garland's conversation with DC Cullen that brought about the Cullen/Meharg investigation. An anonymous allegation of assault on small boys in an unspecified context and at unknown point in time that had been passed by MI5 might not have added much, if anything, to that information. On the other hand, we consider that if it came from MI5 it might have prompted the RUC to look at the existing information it held about McGrath and to investigate it more robustly.

William McGrath

395 Based on our extensive examination of a very large number of files held by RUC Special Branch, by MI5, by SIS and by the Ministry of Defence, we are satisfied that McGrath was never an agent of the State, although he may have enjoyed creating an air of mystery about his activities, part of which may well have involved him hinting at, or implying in an oblique fashion, that he was an agent of the State.

396 Not only have we found no evidence to indicate that McGrath was an agent of any of the four agencies, we have found many documents and references which very strongly indicate that he was not an agent.

397 William McGrath was a sexual pervert who had political and religious views of an extreme and bizarre type who managed to trick gullible young men who were interested in political matters into regarding him as an important

political figure. William McGrath was never more than a minor player on the wider political stage who managed to create a spurious air of self-importance through Tara at a time of great political instability, communal violence and terrorist activity. Tara was never more than an organisation of occasional interest to the security agencies.

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Were prominent individuals involved in the sexual abuse of residents of Kincora

398 There have been frequent allegations that various individuals, including Sir Maurice Oldfield, a former head of the Secret Intelligent Service who was later the Security Coordinator in Northern Ireland, and a number of named and unnamed Northern Ireland Office Civil Servants, and unnamed business men and other prominent figures, resorted to Kincora for sexual purposes. We are satisfied there is no credible evidence to support any of these allegations. Kincora was a small hostel and for most of its existence had only nine or fewer residents at any one time. The great majority of all of those residents who were interviewed by the Sussex Police were very surprised at such allegations and did not believe them to be of any substance.

399 There were a small number of former residents of Kincora who returned to Kincora as visitors and who engaged in consensual homosexual activity with Mains, or on a small number of occasions, with some of the residents. A number of residents engaged in consensual homosexual activity with each other, or did so with others away from Kincora in circumstances which were completely unconnected with Kincora. We are satisfied that Kincora was not a homosexual brothel, nor used by any of the security agencies as a "honey pot" to entrap, blackmail or otherwise exploit homosexuals.

Allegations of a cover up

400 Both the Belfast Town Clerk and the Town Solicitor died before the Hughes Inquiry investigated the sexual abuse at Kincora. The reasons why the Town Clerk and the Town Solicitor decided not to accept the recommendation made by Mr Mason in 1971 that the complaints against Mains should be reported to the RUC were never recorded. There are a number of possible

reasons why they took this step. One was that they did not agree that the information contained in Mr Mason's report was sufficient to justify the matter being reported to the police. If that was their reason then that was a wrong decision. Another reason may have been to protect the Belfast Welfare Authority from the embarrassment that would flow from a police investigation into a boys' hostel under its control. Another explanation may have been that either or both were determined to protect Mains from exposure as a homosexual. That would only be a possible consideration were there evidence to show that either the Town Clerk or the Town Solicitor knew that Mains was a practising homosexual. In the absence of any evidence, each of these possible reasons is no more than speculation.

401 Apart from that unexplained decision, we are satisfied that there were no attempts by the Belfast Welfare Authority or the EHSSB to engage in a "cover-up", that is concealing from relevant individuals or authorities their knowledge of, or information about, wrongdoing by Mains, Semple or McGrath.

Allegations by Colin Wallace and others

402 We are satisfied that Mr Wallace was moved from his post in the Army Information Service at HQNI, and subsequently dismissed, solely because there was very strong circumstantial evidence that he had been engaged in, and was still engaged in, the unauthorised disclosure of classified documents to journalists. We are satisfied that whatever he claims to have known about Kincora had nothing whatever to do with his posting to Preston or his subsequent dismissal.

403 We are satisfied that Mr Wallace was treated unjustly in two respects connected with the subsequent appeal he brought against his dismissal to the Civil Service Appeal Board. First of all the MoD did not reveal to the CSAB the full job description which had been prepared showing the true nature of his work. Secondly, the MoD briefed the Chairman, and then the Deputy Chairman, of the CSAB with information that was not made known to Mr Wallace, to his representative, or to the other members of the Board who sat on his appeal. That they did so, and that the gentleman concerned received the information, was thoroughly reprehensible and should never have happened.

404 These injustices were accepted by David Calcutt QC in his report to the MoD in which he recommended that Mr Wallace be paid £30,000 compensation. We understand that Mr Wallace eventually accepted this amount.

405 We do not regard Mr Wallace as truthful in his accounts of what he knew about sexual abuse in Kincora, or of what he did with that knowledge, between 1972 and 1974. In particular, for the reasons we have given, we do not accept that the critical document of 8 November 1974 was created at that date.

MI5

406 During the Caskey Phase Three investigations MI5 consistently obstructed a proper line of enquiry by their refusal to allow the RUC to interview a retired MI5 officer, and by their refusal to authorise that retired officer to provide a written statement to the RUC answering 30 questions the RUC wished to ask him. We consider these questions were proper and relevant questions to the enquiry being conducted by D/Supt Caskey at that time.

Sir George Terry's report

407 While the Sussex Police carried out a thorough re-examination of the way the RUC carried out the initial Caskey Phase One investigation into the offences committed by Mains, Semple and McGrath, Sir George Terry was not justified in stating that military sources had been "very frank with me and perfectly open".

The NIO and the limited Terms of Reference of the Hughes Inquiry

408 The reliance by the NIO on the decision by the DPP that there should be no prosecution, and on Sir George Terry's Report, as adequate reasons for not setting up an Inquiry with Terms of Reference that would have enabled an investigation of the issues relating to the security agencies was not justified at the time. The decision failed to properly take account of the public disquiet at the time about issues which were deliberately excluded from the Terms of Reference of the Hughes Inquiry.

The steps taken by the Ministry of Defence in 1989 and 1990 to correct incorrect statements

409 The recognition by the MoD in 1989 that incorrect answers may have been given by Ministers to the House of Commons and to others led the MoD to carry out a wide-ranging and detailed investigation to establish the correct position. When the correct position was known, the Ministry took the necessary action to place the correct facts before the House of Commons and to correct the errors that had occurred in the past. It appointed Mr Calcutt QC to consider the injustices suffered by Mr Wallace to which we have already referred. We are satisfied that once the MoD appreciated that incorrect information had been given, and that Mr Wallace had not been treated properly before the CSAB, it acted promptly and properly to establish the correct position, and to ensure that the injustices Mr Wallace suffered in the appeal process were remedied. The injustices were remedied by the payment of £30,000 to him as compensation.

Why the sexual abuse by Mains, Semple and McGrath was not stopped sooner

410 Those residents of Kincora who were sexually abused by Mains, Semple and McGrath were let down by those three individuals who abused their positions of authority and committed numerous acts of sexual abuse of the gravest kind against teenage children in their care while they were living in this hostel. When their conduct was exposed, they were prosecuted, convicted and sentenced to appropriate periods of imprisonment.

411 In our investigations into Kincora the Inquiry examined hundreds of files held by Government and by the Police, MI5, the Secret Intelligence Service (MI6), the Ministry of Defence and other departments and agencies. We have also examined the police files relating to the earlier investigations that were carried out by the RUC and then by the Sussex Constabulary into what did or did not happen at Kincora. As we explained, those investigations by the RUC and the Sussex Police were extremely thorough and comprehensive. D/Supt Caskey and his officers went to great lengths to identify every possible person who may have been in possession of information that could lead to the identification and possible prosecution of anyone else who had committed a criminal offence of whatever kind relating to Kincora, whether that was sexual abuse or the suppression of evidence.

412 Those investigations did not find, and our Inquiry has not found, any credible evidence to show that there is any basis for the allegations that have been made over the years about the involvement of others in sexual abuse of residents in Kincora, or anything to show that the security agencies were complicit in any form of exploitation of sexual abuse in Kincora for any purpose.

413 The reality of the situation was that it was because of the multitude of failings by officials of the Belfast Welfare Authority, of the Eastern Health and Social Services Board, and by the RUC, that the sexual abuse of residents at Kincora was not stopped earlier, and that those responsible for perpetrating these grave crimes were not brought to justice sooner.

Chapter 4:

Recommendations

Introduction

1 The Inquiry's Terms of Reference require the Inquiry to make recommendations and findings on the following matters:

- an apology - by whom and the nature of the apology;
- findings of institutional or state failings in their duties towards the children in their care and if these failings were systemic;
- recommendations as to an appropriate memorial or tribute to those who suffered abuse;
- the requirement or desirability for redress to be provided by the institution and/or the Executive to meet the particular needs of victims.

2 As can be seen from the Terms of Reference, it is for the Northern Ireland Executive to decide whether to accept our recommendations:

> "However, the nature or level of any potential redress (financial or the provision of services) is a matter that the Executive will discuss and agree following receipt of the Inquiry and Investigation report."

3 Throughout the Inquiry we have heard evidence about systemic physical, sexual and emotional abuse of children in institutional care and about neglect and unacceptable practices in children's homes. Whilst we recognise that any recommendations we might make cannot undo the hurt suffered by the survivors of abuse, in making our recommendations we have adopted the following criteria.

- They should, so far as reasonably possible, ensure that the nature and scale of the experiences of children abused whilst in residential institutions in Northern Ireland are appropriately acknowledged.
- Where there were systemic failings on the part of the state and/or the institutions that provided residential care to children under eighteen, that practical forms of redress are made to them.
- Where necessary, appropriate steps are taken to ensure that such abuse and systemic failings are prevented in the future.

4 From the beginning of our work we have given considerable attention to the subject of redress, and conducted our own researches into redress schemes in other jurisdictions. Part of this process involved discussions with those who have been involved with, or have studied, redress schemes for the victims of sexual and other forms of abuse in Canada, Australia, the Republic of Ireland, the Netherlands and Germany. Whilst we found these

discussions extremely helpful, and some of our recommendations echo steps that have been taken in other jurisdictions to provide redress for the victims of historical institutional abuse, each jurisdiction has its own views on what is appropriate, not least in deciding what is the appropriate level at which financial compensation should be paid.

5 Because we believed the recommendations for a redress scheme that we make to the Northern Ireland Executive should take into account the views of those who may be affected by such a scheme, witnesses who gave evidence during the public sessions that they have been abused were asked for their suggestions as to what form of redress might be appropriate. We recognised that witnesses who had already spoken to the Inquiry in public sessions may, on further reflection, have additional suggestions or comments to make on the issue of redress. The witnesses who spoke to the Public Inquiry part of our process were not the only ones whose views we wanted to hear. The 129 applicants who only spoke to the Acknowledgement Forum did not have the same opportunity to make comments and suggestions on the subject of redress, and because they were equally entitled to make comments and suggestions we gave them the same opportunity to give us their views on this subject.

6 We gathered additional evidence by way of a consultation in which we invited comments and suggestions from all our applicants on what form a redress scheme might take. We believe that this was an unprecedented step for a public inquiry to take, certainly for an inquiry in Northern Ireland.

7 The consultation took the form of the questionnaire to be found at Appendix 1, and the numbers of responses to each question are shown in the table in Appendix 2. 541 questionnaires were issued and 330 were returned, a very high return rate of 61% for a document of this type. 232 of those responding added “General Comments”. We have taken the responses into account when formulating our Recommendations.

8 We received information from The Executive Office on aspects of redress schemes for those abused as children in residential institutions in other jurisdictions. We were also sent proposals by a group calling itself “The Panel of Experts” consisting of representatives of groups active on behalf of children abused in some residential institutions, lawyers who acted on behalf of such individuals, and academics with an interest in this field. We have taken this information and these proposals into account when finalising our proposals.

An apology

9 Mixed views were expressed about the desirability of an apology from any institution by applicants who gave their views during the public hearings. Some firmly demanded one, others equally firmly said that they either saw no point in one, or would not accept one if it was given. During each module the core participants had the opportunity to express an apology for any abuse and systemic failings for which they or their predecessors were responsible, and many did so.

10 We believe that an apology can be valuable as a formal recognition by government, or by a public authority, or by an institution, that they, or their predecessors, made mistakes in the way they treated the children in their care. As our conclusions on individual modules make clear, it was not only the religious and voluntary bodies that provided and organised the institutions we investigated that were at fault, we also found systemic failings on the part of the public authorities in the form of County Welfare Authorities, Health and Social Service Boards, the Ministry of Home Affairs, the Department of Health and Social Services and the Northern Ireland Office, when it was responsible for criminal justice institutions, and the RUC.

11 **We recommend that the Northern Ireland Executive and those who were responsible for each of the institutions investigated by the Inquiry where we found systemic failings should make a public apology. The apology should be a wholehearted and unconditional recognition that they failed to protect children from abuse that could and should have been prevented or detected. We also recommend that this should be done on a single occasion at a suitable venue.**

Memorials

12 Physical structures such as sculptures or plaques are valued as visible reminders of past events or individuals whose memory should be commemorated. As in the case of an apology, there were differing views expressed by applicants, many of whom were very strongly of the opinion that a memorial was not appropriate because they did not want to be reminded of their experiences as children in residential institutions. Whilst we respect that view, we are of the opinion that a memorial should be erected to remind legislators and others of what many children experienced in residential homes. **We recommend that a suitable physical memorial**

should be erected in Parliament Buildings, or in the grounds of the Stormont Estate.

13 The design of such a memorial should be chosen by a competition conducted by the Arts Council of Northern Ireland. The Arts Council should invite representatives of those who were abused as children in residential institutions in Northern Ireland to help in the selection of the successful design. The memorial should be paid for by the Northern Ireland Executive.

Additional provision for those who were abused

14 A common theme of the comments by applicants during their evidence at the public hearings, and in their responses to the Questionnaire, was that their experiences as children who were abused had a lasting effect on their lives, and that services should be available to them to enable them to cope with these problems. The areas that were most frequently identified as still causing difficulties for those who were abused we identified in the Questionnaire.

- Mental health problems.
- Other health problems.
- Literacy and numeracy problems.
- Counselling.
- Addiction problems.
- Employment problems.
- Access to education.

15 No single agency can deal effectively with such a multiplicity of issues, but steps to address these issues will need to be co-ordinated to ensure that existing facilities are made readily available to those who need them, and where there are gaps in the services already available these can be identified and remedied. We consider that the best means of addressing the specific needs of those who experienced abuse as children would be by the creation of a post whose holder would act as an advocate for those children who were subjected to abuse whilst under 18 and resident in institutions within our Terms of Reference. **We therefore recommend that a designated person should act as an advocate for such children, and should be responsible for ensuring the co-ordination and availability of services, and identifying suitable means whereby such services can be made available to those who need them.**

This person should be called the Commissioner for Survivors of Institutional Childhood Abuse (COSICA).

16 The Commissioner (who should be assisted by the necessary staff) should be entirely independent of government and the organisations that ran the institutions, but should be funded by government. The Commissioner would have a number of responsibilities.

(a) Act as an advocate for all those who were abused as children in residential institutions in Northern Ireland between 1922 and 1995.

(b) Encourage the co-ordination and provision of relevant services free of charge for those who were so abused.

(c) Provide a central point of contact for providing advice on the services and facilities available; and provide assistance to those who suffered abuse to contact those services. This would include providing a hotline and internet advice.

(d) Be responsible for monitoring the matters referred to at 22 (a) and (b) below.

(e) Assist in the provision of advice and information to those who wish to apply for compensation to the HIA Redress Board proposed below.

(f) Assist people to access records about the time they spent in homes including admission and discharge dates to enable them to apply for compensation to the HIA Redress Board proposed below.

(g) Monitor the operation of the HIA Redress Board proposed below.

17 **We recommend the Commissioner should be assisted by an Advisory Panel consisting of individuals who as children were resident in residential homes in Northern Ireland. The members of the Advisory Panel should be chosen by the First Minister and deputy First Minister in accordance with the normal processes for public appointments in Northern Ireland.**

18 We understand that The Executive Office has funded a number of groups of former residents of residential homes for children, and **we recommend that such funding should continue on a transitional basis until such time as the members of the Advisory Panel have been appointed.**

19 The operation of, and need for, COSICA should be reviewed after five years.

20 Our Terms of Reference were limited to abuse that occurred in those institutions that came within our Terms of Reference, but we heard some

evidence of abuse of children in other circumstances, such as schools or foster care. It is not for us to say whether there should be other inquiries into allegations of abuse and systemic failings in such areas. However, if our Recommendations are implemented, we suggest that consideration be given to expanding the functions of COSICA as necessary to include other forms of abuse suffered by children, such as clerical abuse, abuse in schools or abuse suffered whilst in foster care.

21 So that the Commissioner would be, and would be seen to be, independent, and to ensure that the office would be adequately resourced, the office of Commissioner should be:

(a) created by statute;

(b) allocated a separate budget; and

(c) required to report once a year to the NI Assembly.

Specialist care and assistance

22 Sufficient funds should be made available by government on a ring-fenced basis for a fixed period of ten years, subject to a review after five years, to establish dedicated specialist facilities in Belfast, Derry and, if necessary, at other suitable locations across Northern Ireland to provide:

(a) general counselling services for those who have suffered abuse as children in residential institutions in Northern Ireland, supported by appropriate links to the health service and to other relevant housing, education and employment services; and

(b) practical help with literacy and numeracy, education, employment, housing and benefits advice tailored to the needs of individual victims of institutional abuse.

Financial compensation

23 On 4 November 2015 we announced that, based on the evidence we had heard, we would recommend that compensation should be payable to those who had been abused whilst in residential children's homes within our Terms of Reference.

24 The great majority of redress schemes that we have considered throughout the English-speaking world provide for lump sum payments to those entitled. Some argue that a more sensible form of redress would be to provide regular payments in the form of a benefit or pension, thereby

ensuring that the money is regularly available and is less likely to be dissipated unwisely. Whilst we can see some validity in that argument, we consider that a lump sum payment is preferable for a number of reasons.

- The recipient has the benefit of a lump sum to use as he or she thinks best, for example by giving some or all of the money to their children, by purchasing an annuity, or by paying for the cost of travel to the United Kingdom or Ireland to have contact with relatives.
- It is easier to identify the possible total cost of the redress.
- It is easier to administer, particularly if a redress scheme is time limited, and does not require a permanent organisation to be created and staffed as would be the case were the compensation to take the form of regular payments.

We therefore recommend that compensation should take the form of a lump sum payment.

25 Although some have argued that the institutions responsible for any abuse should be responsible for compensation, it must be remembered that the Inquiry has not investigated every institution in respect of which there have been allegations of abuse. As well as those we examined during our public hearings, as we explained on 4 November 2015 there were some other homes that were subject to specific, targeted investigations.

26 In addition there were another 43 homes or institutions where we decided that any further investigations into them would not be justified. This was because we were satisfied that further investigations were neither necessary nor proportionate, and would not add to our understanding of the nature and extent of systemic abuse of children in homes and institutions in Northern Ireland within our Terms of Reference. We emphasised that this did not mean that we had decided that abuse did not occur in those homes or institutions. Any compensation scheme has therefore to provide for those who may have been abused in homes or institutions that we did not investigate.

27 In addition, there may well be applications for compensation by individuals who were abused in homes or institutions against which no complaints were made to us. Some of those homes or institutions may no longer exist, nor may the organisations that ran them. Even if they do exist, those responsible for them now may not have sufficient funds to pay compensation, or may not be covered by insurance. If compensation were only payable by those responsible for the homes we investigated, and

have the funds to pay, that would mean that many who were abused might not receive compensation.

28 A further important factor is that we have found that employees of local authorities, health boards and Government departments were also guilty of abuse. In addition, these organisations were guilty of systemic failings in the homes or institutions they organised, such as Rathgael, Millisle, Lissue, Kincora and Bawnmore, or were responsible for inspecting in the case of the Ministry of Home Affairs and the DHSS.

29 For these reasons we believe that only a government-funded compensation scheme can ensure that all of these contingencies are provided for. If such a scheme is not provided, it is likely that many of those who should be compensated will not be compensated. **We recommend that the Northern Ireland Executive create a publicly funded compensation scheme.**

The HIA Redress Board

30 This publicly funded compensation scheme should be distinct from the Northern Ireland Criminal Injuries Compensation Scheme 2009 (The 2009 Scheme). As there will be similarities to the 2009 Scheme we considered whether the most effective and economical way to administer such a compensation scheme would be through Compensation Services who administer the 2009 Scheme. However, as we understand the position, in practical terms Compensation Services operates in a different fashion to the compensation scheme we propose below. First of all, when deciding whether an application comes within the 2009 Scheme it is dependent on information provided by the PSNI following a police investigation into the criminal offence(s). Secondly, in assessing the amount of compensation to be awarded it applies a tariff-based scheme to identify where on a wide scale of injuries the applicant's injury or injuries can be said to fall. The amount(s) prescribed by the tariff scheme is then selected.

31 Whilst such an approach is no doubt appropriate for a permanent compensation scheme where the facts of each case have been investigated by the police, we consider that such an approach would not be appropriate for a compensation scheme covering a wide range of different institutions where different conditions prevailed at different times, where the circumstances of individual applicants should be individually assessed, and where not every institution has been investigated by our Inquiry.

32 **We consider the appropriate method of administering the compensation scheme is to create a specific Historic Institutional Abuse Redress Board for that purpose, and we so recommend. The HIA Redress Board should be responsible for receiving and processing applications for, and making payments of, compensation.**

33 **It should be set up by the Northern Ireland Executive and consist of a Chief Executive and such administrative staff as required to administer the HIA Redress Board.**

34 **The HIA Redress Board would also consist of such judicial members as may be required, one of whom should be appointed by the Lord Chief Justice as President of the Redress Board.**

35 **The Chief Executive would be the accounting officer for the HIA Redress Board, and responsible for the administration of the HIA Redress Board, but would be obliged to comply with all directions given by the President of the Redress Board for the allocation of business to, and the discharge of functions by, a judicial member, whether sitting as a single member or as a member of the Appeal Panel.**

36 **The President of the Redress Board would be responsible for all matters relating to the discharge of functions by the judicial members.**

37 We consider that the decisions to be made by the judicial members of the HIA Redress Board would be of the type made by judges in civil proceedings. In order that the judicial members would be seen to have the necessary experience and independence **we recommend that the judicial members be appointed by the Lord Chief Justice and be persons who hold, or who have held, judicial office as judges of the Court of Judicature in Northern Ireland or of the County Courts in Northern Ireland.**

38 **We recommend (a) that a sufficient number of judicial members be appointed as members of the HIA Redress Board. Each judicial member should be remunerated on a fee paid basis for each day or half day they were engaged on the business of the HIA Redress Board. (b) Rules governing the applications for compensation, and the procedures to be followed by the judicial members, including the Appeal Panel, should be made by the Department of the Northern Ireland Executive responsible for the funding of the HIA Redress Board, subject to the consent of the Lord Chief Justice.**

Procedures for awarding compensation

39 Many applicants to the HIA Inquiry who apply to the HIA Redress Board will have given their account of their experiences on more than one occasion. In addition, in order for a decision to be made whether they are entitled to compensation, and if so what the amount of compensation should be, it may be necessary to explore sensitive personal matters that many victims of abuse would find it upsetting to have to discuss in a public forum. **We therefore recommend that the judicial member and the Appeal Panel should make decisions as to whether compensation should be paid, and if so, the amount to be paid, solely on the basis of the written material submitted by the applicant, and any other written material the judicial member or the Appeal Panel consider relevant.**

40 **We recommend that the Redress Board should be structured in the following way.**

(a) A single judicial member of the HIA Redress Board should decide whether compensation should be payable, and if it is payable, the amount to be paid. Brief reasons for the decision should be given in writing.

(b) A person or persons dissatisfied by the decision of the single judicial member of the HIA Redress Board should be entitled to appeal to an Appeal Panel whose decision would be final.

(c) The Appeal Panel would consist of three other judicial members of the HIA Redress Board selected by the President of the Redress Board.

(d) The Appeal Panel would make their decision on the same materials that were before the judicial member.

(e) The appeal would take the form of a complete reconsideration of the application.

(f) The Appeal Panel should have the power to affirm the decision of the judicial member, or to substitute its decision for that of the judicial member, including the power to vary the order made by the judicial member by awarding a higher or lower figure for compensation.

(g) In exceptional circumstances if it is necessary in the interests of justice the single judicial member or the Appeal Panel should have the power to (i) admit fresh evidence, and (ii) order an oral hearing.

(h) Any oral hearing, whether by a single judicial member or the Appeal Panel should be held in private.

(i) Decisions of the Appeal Panel should be by a majority, and the reason(s) for the decision should be given briefly in writing to the applicant and any other person the single member or the Appeal Panel consider should receive a copy of the decision.

Eligibility for compensation

41 We consider compensation should not be payable to anyone merely because they were resident in an institution within our Terms of Reference. Many of those who were resident in these institutions were not abused in any way, and we consider there is no justification for awarding compensation to individuals merely because they were in homes where others were abused, but they were not themselves abused, and were unaware of abuse taking place.

42 **We therefore recommend that compensation awarded by the HIA Redress Board should only be payable to, or in respect of, a person who can show (or their estate can show) on the balance of probabilities that they:**

(a) suffered abuse in the form of sexual, physical or emotional abuse, or neglect or unacceptable practices, between 1922 and 1995; and

(b) were resident in a residential institution in Northern Ireland as defined by the Terms of Reference of the HIA Inquiry when they suffered the abuse; and

(c) were under 18 at the time.

43 In some, though not all, of the institutions we investigated there was a harsh environment that affected all the children in that institution at that time. Other children who were exposed to that harsh environment, but were not themselves abused, were still affected by the general regime and the impact of what they witnessed, and therefore were also abused. **We recommend that such persons also should be regarded as having been abused and should also be eligible for an award of compensation by the HIA Redress Board.**

44 **Living persons should be eligible to receive a full payment.**

45 Not all redress schemes allow the surviving spouse or children of a person who was abused but who died before they could receive compensation to receive all or part of the amount the person would have had they lived. Payment under a redress scheme is designed to compensate an abused person for the effect of the abuse on him or her. However, many applicants to the Inquiry stressed the adverse effect of their experiences upon their adult lives when it came to being a spouse or parent, and said their families suffered as a result of their parent's experiences. We accept that was the case for many of those who spoke to us.

46 An additional consideration is what happens to those who were abused but died before they could claim compensation, or before their claim was dealt with. We are aware that, so far, at least eleven applicants to the Inquiry have died since they made their application, and sadly more may die before the HIA Redress Board could come into operation, or before their claim may be dealt with by the HIA Redress Board.

47 **We believe that it would be just and humane for only those directly affected, namely the spouse or children of a person who died after a prescribed date to be able to claim 75% of the compensation that would have been awarded to their spouse or parent, and we so recommend.** The Northern Ireland Executive announced that it intended to set up an Inquiry on 29 September 2011, and **we recommend that that should be the prescribed date, and that any person living on that date should be entitled to compensation from the HIA Redress Board.**

48 Where a person entitled to compensation died after 29 September 2011 we recommend that the following provisions should apply.

(a) Only the spouse or children of the deceased should be able to recover 75% of the award that would have been made to the person had he or she survived.

(b) Those entitled to the 75% proportion of the award will be the beneficiary or beneficiaries of the person's estate where the victim left a will. If the person died without leaving a will then the entitlement will be decided in accordance with the law of the country in which the person resided at the time of his or her death.

(c) Where more than one person is entitled to share in the estate of the deceased their respective shares will be decided in

accordance with the law of the country in which the person lived at the time of his or her death.

49 We believe that a person should not be entitled to be compensated twice for abuse they suffered. **If a person has already received compensation through civil proceedings for his or her time in a residential institution within our Terms of Reference we recommend that person should not be entitled to a payment from the HIA Redress Board.**

50 **A person who has instituted civil proceedings against an institution or a public body or a government department for abuse suffered by that person whilst under 18 in a residential institution in Northern Ireland within our Terms of Reference must decide whether to continue his or her civil action or apply to the HIA Redress Board. They should not be able to do both, and must terminate those civil proceedings in a final manner before they apply to the HIA Redress Board.**

51 **We consider that a person who wishes to institute, or continue, civil proceedings instead of applying for compensation to the HIA Redress Board should be entitled to do so, but should not be able to top up any payments they have received, or may receive, by applying to the HIA Redress Board in the hope of obtaining a further payment in respect of abuse suffered in the same institution.**

52 **However, for the avoidance of doubt we wish to make it clear that this would not prevent a person who has already received compensation in civil proceedings in respect of abuse suffered whilst a resident in one institution from receiving compensation from the HIA Redress Board for abuse suffered whist resident in a different institution, provided that institution was not managed by the same organisation against whom the earlier civil proceedings were taken.**

53 To allow applicants to claim in civil proceedings and from the HIA Redress Board would be contrary to the principle that compensation from the HIA Redress Board should be an alternative, and not a supplement, to compensation received as a result of civil proceedings.

54 To allow applicants who have accepted settlements, or who have instituted civil proceedings that were unsuccessful, would be contrary to the principle that litigation should be final; would cause difficulties for the courts and HIA Redress Board in deciding which case was to be dealt with first; and would cause difficulties for the courts and HIA Redress Board when deciding what the other had already taken into account and why.

55 However, in one instance only we consider that those who have been unsuccessful in civil proceedings based on abuse they suffered under the age of eighteen while in residential institutions in Northern Ireland should still be allowed to claim from the HIA Redress Board. As can be seen from the decisions in *McKee v Sisters of Nazareth and Irvine (Una) v Sisters of Nazareth* to which we refer below, claims for abuse suffered by former residents in institutions within our Terms of Reference brought by way of civil proceedings can be defeated by the operation of the limitation defence.

56 Possible changes in that defence in civil proceedings raise complex issues which are not for us to address, but we have recommended that compensation should be paid under the HIA Redress Scheme to anyone who suffered abuse between 1922 and 1995. We consider that it would be unjust if the small number of individuals whose claims in civil proceedings were defeated solely because of the application of the limitation defence were not to receive compensation from the HIA Redress Board when others who suffered abuse during the period 1922 to 1995 would be compensated by the HIA Redress Board. **We therefore recommend that a person who brought civil proceedings based on abuse in institutions within our Terms of Reference whose cases were dismissed solely because of the operation of the limitation defence should not thereby be disqualified from claiming compensation from the HIA Redress Board.**

57 We also make the following recommendations relating to the payment of compensation by the HIA Redress Board:

(a) It should not be a requirement for the payment of compensation that the person has to have reported the abuse to the police, nor should it be a requirement that the person engaged with the HIA Inquiry.

(b) Criminal convictions should not result in the withholding of, or the reduction of, compensation otherwise payable. It should not be a bar to compensation if the abuse happened within a family in the case of a child who had been placed by a residential institution with a family for a short time.

(c) It should not be a bar to compensation that the abuse occurred outside the physical boundaries of an institution but within its area of responsibility. For example, abuse that occurred on camping trips or holidays organised by the institution, or when a child had been placed by the institution with a family, or in

the care of a volunteer authorised by the institution, should result in compensation.

Compensation procedures

58 A number of important practical aspects of the procedures for applications for compensation to the HIA Redress Board have to be provided for if those procedures are to be as straightforward, effective, and efficient as possible, **and the following recommendations are intended to enable these objectives to be achieved.**

(a) The statement of a person who made a statement to the Statutory Inquiry or to the Acknowledgement Forum if they did not also apply to the Statutory Inquiry should be accepted as the basis for compensation unless the person did not appear to give evidence to the Statutory Inquiry when requested to do so.

(b) The application forms for, and the procedure for assessing entitlement to, compensation must be designed in such a way as to be simple and user-friendly so as not to be off-putting to applicants.

(c) The judicial members of the HIA Redress Board should apply the definition of abuse used by the Inquiry, and take the findings of the Inquiry into account when considering whether an individual person was abused.

59 Many have urged that a redress scheme be set up as a matter of urgency, not least because many applicants to the Inquiry were elderly or in poor health, and may not live to receive compensation if it takes a long time to set up a redress scheme. Whether the HIA Redress Board is put on a statutory or on an *ex gratia* basis, we urge the speedy implementation of our Recommendations.

60 As we have provided a detailed framework for the recommended compensation scheme and for the HIA Redress Board that would administer the compensation scheme we consider that if the implementation of our recommendations is addressed by the Northern Ireland Executive and Assembly in a positive and energetic fashion any legislative or administrative procedures that are required to create the HIA Redress Board can be put in place in time to enable the first payments to be made by the HIA Redress Board by the end of 2017.

61 **We recommend that priority is given by the HIA Redress Board to those applicants who are over 70 or in poor health.**

62 The Inquiry gave anonymity to applicants, although some chose to waive that anonymity. We intend that anonymity should continue indefinitely. The Inquiry also gathered a great deal of information, some of which is specific to the person concerned, such as their social services records, or is important to a proper understanding of the circumstances surrounding their time in institutions. This would include records held by the police or the institution concerned which would have a bearing on the proper level of compensation. Examples include witness statements made where there were complaints to the police, or admission records showing the time an individual spent in different institutions, because quite understandably many are not sure of the exact dates when they were in a particular institution, especially if they were in more than one institution.

63 While much information relevant to compensation is contained in the transcripts of the evidence relating to particular individuals, where the identity of that individual is covered by a designation that could be a significant impediment to establishing the necessary facts upon which an award of compensation should be made by the HIA Redress Board. Many documents such as social services records contain information about parents and other family members that may be relevant, but which should not be publicly available.

64 The Inquiry does not intend to place all the documents we have gathered in the public domain, but we will place such material in the Public Record Office for Northern Ireland (PRONI) subject to the condition that access is prohibited for 100 years.

65 To enable a person who applied to the Inquiry to seek compensation from the HIA Redress Board **we recommend that PRONI may only give access to material lodged by the Inquiry to an applicant to the HIA Redress Board where the applicant agrees to disclose his or her full name, date of birth and such other details that the HIA Redress Board reasonably considers necessary to decide whether compensation should be paid by the HIA Redress Board, and if compensation should be paid, the amount of the compensation.**

66 **We recommend that those details, and the relevant material relating to the applicant, shall only be disclosed by PRONI to the applicant and to the HIA Redress Board as either may reasonably require**

in order to decide whether compensation should be paid to the applicant, but, subject to the next paragraph, shall not be disclosed to anyone else without the written consent of the applicant.

67 **We recognise that there may be circumstances where a court in Northern Ireland considers that the interests of justice require the disclosure of such material deposited by the Inquiry with PRONI, and we recommend that regulations be made to enable such court orders to be complied with.**

68 We recognise that in some cases, particularly if claims are made for compensation for abuse alleged to have been suffered in any institution that was not investigated by the Inquiry, it may be necessary for the HIA Redress Board to put in place procedures to give notice to the institution concerned, or its successor if there is one, and to an identifiable individual who is alleged to have committed the alleged abuse, or who could give information about the allegation, to provide that information to the HIA Redress Board. We recommend that the HIA Redress Board put in place such procedures as may be necessary to enable such steps to be taken, and that the necessary powers be provided to enable this to be done.

Amount of compensation

69 As part of our consideration of the issue of compensation, and who should be compensated, and what the amount of compensation should be, we gathered information about as many civil claims that have been brought against institutions within our Terms of Reference as we could. We then analysed the awards to see what amounts of compensation had been awarded to, or accepted by way of settlement, by plaintiffs who had taken civil action against any of these institutions in Northern Ireland.

70 We believe that such an exercise on such a scale has never been attempted before in the United Kingdom because of the difficulty in obtaining information in respect of awards in civil claims against institutions within our Terms of Reference as many have been settled on confidential terms. We exercised our powers under section 9 of the Inquiry into Historical Institutional Abuse Act (Northern Ireland) 2013 to require the provision of this information. Whilst we regard the details of individual awards as confidential, we have been able to gather much relevant information, the results of which are contained in Tables 1 and 2 in Appendix 3.

71 We know that 147 applicants to the Inquiry have instituted civil proceedings, and 67 individuals who did not apply to the Inquiry have also done so. We have established that of the 214 cases, 34 cases brought by applicants to the Inquiry, and 33 cases brought by individuals who did not apply to the Inquiry, resulted in payments being made to the plaintiff. We understand that 147 cases are therefore still unresolved.

72 We analysed the amounts that have been accepted in settlement by those who have taken civil proceedings, and the results are shown in the Tables at Appendix 3 to this Chapter. As the figures show, of the 67 cases where compensation has been paid as the result of civil proceedings in Northern Ireland no settlement has been for less than £5,000; and only seventeen settlements exceeded £20,000. Of those seventeen cases, only seven exceeded £30,000. Of the seven settlements over £30,000 the highest settlement figure was £60,000, and that was in only one case. We consider that the amounts to be paid by the HIA Redress Board should be in line with the amounts that litigants who have taken civil proceedings in Northern Ireland have received in respect of abuse suffered whilst they were residents in institutions within our Terms of Reference.

73 We have also taken into account the recent decisions in the High Court of Justice in Northern Ireland *McKee v Sisters of Nazareth [2015] NIQB 93 and Irvine (Una) v Sisters of Nazareth* [2015] NIQB 94. In both cases the actions were dismissed because the plaintiff could not overcome the limitation defence, but Mr Justice Horner and Mr Justice Colton respectively helpfully indicated the amounts they would have awarded the plaintiffs had their cases succeeded. In McKee Mr Justice Horner felt that the range of damages would have been between £5,000 and £7,500, and the award would have been £6,500. In that case the judge said that he would have awarded:

> "…a modest sum to reflect the nature of the harsh and brutal regime that was in place at Nazareth Lodge during [Mr McKee's] short time there."

74 In *Irvine* Mr Justice Colton accepted that the plaintiff:

> "…was subjected to corporal punishment which went beyond what was reasonable or lawful. An obvious example of this was her being punished by being struck with a stick with nails in it after she had been stealing apples from a nearby orchard. I also accept that she was subjected to unlawful assaults by way of discipline in particular from

> Sister Coleman. There is also in my view credibility to her allegation that she was not permitted to go to the toilet when she wet herself and that generally she was subject to a harsh and uncaring regime...In terms of physical injuries it does not appear that the Plaintiff sustained any significant injuries. At no stage for example did she require medical assistance because of any assaults. Nonetheless, on the Plaintiff's evidence assaults were fairly frequent and occurred over a sustained period of time. For the physical injuries suffered by the plaintiff I would have awarded £7,500."

The judge dealt with a claim for psychiatric injuries in the following passages of his judgment.

> "The main complaint relates to the emotional trauma suffered by the Plaintiff and psychiatric injury. By reason of the assaults to which I have referred and to the overall harsh nature of her care the Plaintiff alleges that she has suffered both emotional stress and psychiatric injury... This is not a case where the Plaintiff can establish that as a result of tortious acts by the defendant she has suffered an actual psychiatric injury. At best she has been rendered vulnerable to psychiatric injury and that injury has materialised because of other stressors in her life. Had it not been for the limitation defence my judgment is that a figure of £20,000 would be an appropriate award for this aspect of the case having regard to the medical evidence which I heard and carefully considered."

The judge therefore indicated that he would have awarded the plaintiff £27,500 in total had her case not been defeated by the limitation defence. Whilst the plaintiffs' claims in both cases were defeated by the operation of the limitation defence, their experiences were typical of many applicants who gave evidence to our Inquiry.

75 We do not consider that there is any reason why awards by the HIA Redress Board should be materially out of line with amounts that have been already been paid as a result of litigation, whether against individual institutions or public authorities, or by the state in the form of Criminal Injury Compensation, or which may be awarded by the courts. We believe that such awards are the appropriate benchmark against which awards by the HIA Redress Board in this jurisdiction should be measured.

76 We consider that there should be a minimum amount that would be awarded to a person who can show that they have been abused in a

residential institution, and that the upper limit of awards should be capped at a figure that would be sufficient to provide fair compensation for the worst cases, taking into account the highest settlements that there have been to date on the basis that there are likely to be few such awards by the HIA Redress Board, whilst leaving a certain amount of headroom in case a small number of cases are brought that would justify awards between £60,000 and £80,000. In what we believe would be a handful of cases where awards exceeding £80,000 (or £100,000 in the case of Australian applicants) might conceivably arise, the option of civil proceedings with an unlimited award would continue to be available.

77 Some applicants believe that had they not been abused whilst resident in a children's home that they would have had had more success in life, and so earned more money. We consider that if a person wishes to claim for loss of earnings in adult life then they should pursue such a claim for loss of earnings as part of a claim in civil proceedings, and that claims for loss of earnings should not be allowed under the capped compensation scheme we recommend.

78 **We therefore recommend that every person entitled to compensation should receive a standard award sufficient to cover those forms of abuse that were widespread and suffered by a significant number of children, such as unacceptable living conditions, excessive domestic work, loss of earnings for excessive work done by children in children's homes, minor physical abuse, or being subjected to emotionally abusive behaviour, but not for any other form of loss of earnings.**

79 **Those who may have been more significantly affected, or who were subjected to more serious forms of abuse of any type, such as sexual abuse or serious physical abuse, would be entitled to an enhanced payment from the HIA Redress Board.**

80 **Those sent to Australia under the Child Migrants Scheme should receive a special payment in addition to any other payment to which they might be awarded by the HIA Redress Board. The special payment should be of a sum sufficient to recognise the injustice they suffered as young children by being sent to a far away land and losing their sense of identity as a result.**

81 **We recommend that the amount of compensation should therefore consist of one or more of the following elements.**

(i) A standard payment of £7,500 payable to anyone who was abused, including those who experienced a harsh environment, or who witnessed such abuse.

(ii) An additional payment of £20,000 in respect of a person sent to Australia under the Child Migrants Scheme.

(iii) An additional enhanced payment to anyone who was more severely abused.

82 **The maximum amount of compensation payable in respect of (i) and (iii) should not exceed £80,000, and the maximum payment in respect of (i), (ii) and (iii) should not exceed £100,000.**

83 **We also recommend that social security payments should not be affected by lump sum payments awarded by the HIA Redress Board.**

84 Lump sum payments of damages for personal injury, or by way of criminal injury compensation, are not taxable, and we consider that lump sum payments made by the HIA Redress Board should be treated in the same way. **We recommend that payments of compensation should not be taxable, and that the Northern Ireland Executive make representations to the Treasury and to HMRC to achieve this.**

Legal Aid

85 We accept that in order for them to pursue their claims effectively applicants to the HIA Redress Board, particularly those who were resident in an institution not investigated by the Inquiry, will require legal representation in order to obtain the necessary evidence to bring their application. **We recommend that applicants should be eligible for legal aid to allow them to obtain legal assistance to make an application for an award.**

86 **We recommend that the costs of a successful application should be paid to the applicant's legal representatives on the County Court Scale. The County Court Rules Committee should be invited to suggest a scale of costs for cases for awards between £30,000 and £80,000. No additional costs should be payable where the award is between £80,000 and £100,000 because anyone who went to Australia under the Child Migrant Scheme would receive a fixed award of £20,000 and so there would be no real additional work or responsibility that would justify an extra fee for an award over £80,000.**

87 As the Table in Appendix 3 shows, the overwhelming majority of civil abuse cases have been settled for amounts below £30,000, and we see no reason to assume that awards by the HIA Redress Board should not follow a similar pattern. This assumption is subject to the caveat that it is not possible to predict how many people may apply to the HIA Redress Board, or what the amounts of compensation are to which individuals might be entitled.

88 However, not every applicant who was a resident in any institution would be eligible because in most institutions there was not a harsh environment of the type that we found existed at certain times within the homes run by the Sisters of Nazareth and the De La Salle Order. In some institutions there were instances of abuse but overall standards of child care were satisfactory.

89 In the case of those who were sent to Australia when they were so young that they have no recollection of their experiences in the homes in Northern Ireland before they were sent then such individuals should not receive the standard payment but would receive the special payment of £20,000. A person who could recall the harsh environment in the institution from which they were sent to Australia should receive the standard payment of £7,500 and the special payment of £20,000, a total of £27,500. A person who was sent to Australia and who could show that they had been more significantly affected, or who were subjected to more serious forms of abuse of any type, such as sexual abuse or serious physical abuse, would be also be entitled to an enhanced payment, but could not receive more than the maximum capped award of £100,000.

90 We consider that the operation of the HIA Redress Board should not continue indefinitely, but should be time limited, with a reasonable period being allowed in which prospective applicants could be expected to make an application for compensation. **We recommend that applications must be made within five years from the coming into existence of the HIA Redress Board, which should then close to new applicants after that date.** If other forms of abuse such as clerical abuse, or abuse in schools, were to be added to the HIA Redress Board then the five year period might have to be amended accordingly.

91 **We recommend that the existence of the HIA Redress Board should be adequately publicised in Northern Ireland and elsewhere, and that once the Commissioner's post has been filled such publicity should**

be the responsibility of the Commissioner. Until the Commissioner's post is filled The Executive Office should be responsible for publicity about the HIA Redress Board.

92 **We recommend that the Regulation and Quality Improvement Authority (RQIA) and the Northern Ireland Social Care Council should have regard to any recommendations made to them by the Commissioner about practice issues relating to residential care.**

Contributions to the cost of the compensation scheme

93 There is a widely expressed view, which we believe to be valid, that the total cost of compensation awarded to the victims of historical institutional abuse should not fall completely on the taxpayer. **We recommend that any voluntary institution found by the Inquiry to have been guilty of systemic failings should be asked to make an appropriate financial contribution to the overall cost of the HIA Redress Board and any specialist support services recommended by the Inquiry.**

94 The amount, and how it would be paid, should be negotiated between the Government and the institution(s) concerned in the first instance. For example institutions may wish to argue that their funds, or their other obligations, are such that they are not in position to make such a contribution, or, in the case of institutions that have already made payments, that the payments or other outlay such as travel costs from Australia, should be taken into account and set off against any contribution to which they may be asked to make so that they do not pay twice over for their failings.

95 If agreement as to the amount(s) to be paid by the institution(s) cannot be reached, **we recommend that the Northern Ireland Executive and the institution(s) concerned submit all issues to mediation. If mediation fails then all remaining issues should be dealt with by the Northern Ireland Executive and the relevant institutions agreeing to submit to binding arbitration.**

APPENDIX I - Questionnaire

Name (optional): _____

Questionnaire

In this questionnaire "*abuse*" means "*abuse suffered by an individual while they resided in a residential home (other than a school)*."

	FINANCIAL COMPENSATION	YES	NO
Q1	Should all victims of abuse receive financial compensation? *(if 'Yes' go to Q2)*	☐	☐
Q2	Should all victims of abuse receive:		
(a)	The same amount of compensation? *(if 'Yes' go to Q3)*	☐	☐
(b)	Should the amount of compensation vary depending upon the amount and type of abuse suffered by the victim?	☐	☐
(c)	Should there be an upper limit on the amount of compensation?	☐	☐
Q3	If a victim of abuse dies before any redress scheme comes into operation, should the amount of compensation that person would have been entitled to if they were still alive be capable of being passed to someone else? *(if 'Yes' go to Q4)*	☐	☐
Q4	Should the amount to be inherited be:		
(a)	100% of the amount of compensation to which the victim would have been entitled?	☐	☐
(b)	A lower percentage? *(specify below)*	☐	☐
(c)	Specify percentage eg 75%, 50%, 25%?	_____	%

(continue overleaf)

OTHER FORMS OF REDRESS		YES	NO
Q5	Should there be a scheme for the victims of abuse to receive assistance with: *(tick all that apply)*		
(a)	Mental health problems ❒		
(b)	Other health problems ❒		
(c)	Literacy and numeracy problems ❒		
(d)	Counselling ❒		
(e)	Any other form of assistance ❒		
(f)	Addiction problems ❒		
(g)	Employment problems ❒		
(h)	Access to education ❒		
Q6	Should any form of assistance provided by way of redress to a victim of abuse be:		
(a)	Instead of, or	☐	☐
(b)	In addition to financial compensation?	☐	☐

General Comments

(continue on another page if necessary)

You can return this form either by using enclosed pre-paid envelope or by email to general@hiainquiry.org. The closing date is ***8 January 2016***

Appendix 2 – Summary of Responses

No.	Questions	Yes	%	No	%	Not returned or no answer[1]		No. Issued
Q1	Should all victims of abuse receive financial compensation?	324	60%	4	1%	213	39%	541
Q2	Should all victims of abuse receive:							
Q2 a	The same amount of compensation? *(If 'Yes' go to Q3)*	135	25%	144	27%	262	48%	541
Q2 b	Should the amount of compensation vary depending upon the amount and type of abuse suffered by the victim?	177	33%	27	5%	337	62%	541
Q2 c	Should there be an upper limit on the amount of compensation?	69	13%	113	21%	359	66%	541
Q3	If a victim of abuse dies before any redress scheme comes into operation, should the amount of compensation that person would have been entitled to if they were still alive be capable of being passed to someone else? *(if 'Yes' go to Q4)*	305	56%	22	4%	214	40%	541
Q4	Should the amount to be inherited be:							
Q4 a	100% of the amount of compensation to which the victim would have been entitled?	282	52%	16	3%	243	45%	541
Q4 b	A lower percentage?	18	3%	10	2%	513	95%	541

1 This column shows the number of those who either did not return the questionnaire or did not answer the question.

No.	Questions	Yes	%	No	%	Not returned or no answer[1]		No. Issued
Q4 c	Specify percentage eg 75%, 50%, 25%[2]							
Q5	Should there be a scheme for the victims of abuse to receive assistance with:							
Q5 a	Mental health problems	293	54%	0	0%	248	46%	541
Q5 b	Other health problems	267	49%	0	0%	274	51%	541
Q5 c	Literacy and numeracy problems	232	43%	0	0%	309	57%	541
Q5 d	Counselling	280	52%	0	0%	261	48%	541
Q5 e	Addiction problems	254	47%	0	0%	287	53%	541
Q5 f	Employment problems	227	42%	0	0%	314	58%	541
Q5 g	Access to education	243	45%	0	0%	298	55%	541
Q5 h	Any other form of assistance	222	41%	0	0%	319	59%	541
Q6	Should any form of assistance provided by way of redress to a victim of abuse be:							
Q6 a	Instead of, or	30	6%	117	22%	394	73%	541
Q6 b	In addition to financial compensation?	273	50%	18	3%	250	46%	541

2 Less than 10% of those who answered this question suggested figures other than 100%.

Appendix 3

Table 1

CLAIMS BY APPLICANTS SETTLEMENT BANDS

Bands (£)	Number of settlements
7,000 - 10,000	11
10,001 - 12,500	2
12,501 - 15,000	8
15,001 - 17,500	0
17,501 - 20,000	2
20,001 - 22,500	2
22,501 - 25,000	1
25,001 - 27,500	0
27,501 - 30,000	2
30,001 - 40,000	4
40,001 - 50,000	1
50,001 - 60,000	1
34	TOTAL

£716,500	TOTAL AMOUNT PAID	
£21,074	AVERAGE PAYMENT	

Payments made

34 claims (with settlement figures available)

- Total paid out
  - ➢ £716,500.00
- Maximum payment
  - ➢ £60,000.00
- Minimum payment
  - ➢ £7,000.00
- Average payment
  - ➢ £21,074.00

Table 2

CLAIMS BY NON-APPLICANTS SETTLEMENT BANDS

Bands (£)	Number of settlements
5,000 - 7,500	9
7,501 - 10,000	2
10,001 - 12,500	0
12,501 - 15,000	5
15,001 - 17,500	2
17,501 - 20,000	10
20,001 - 22,500	0
22,501 - 25,000	3
25,001 - 27,500	1
27,501 - 30,000	0
30,001 - 40,000	1
40,001 - 50,000	0
50,001 - 60,000	0
33	TOTAL

£521,000	TOTAL AMOUNT PAID	
£15,788	AVERAGE PAYMENT	

Payments made: Non-Applicants (NI payments)

33 claims settled

- Total paid out
  - ➢ £521,000.00
- Maximum payment
  - ➢ £35,000.00
- Minimum payment
  - ➢ £5,000.00
- Average payment
  - ➢ £15,788.00

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Chapter 5:

Module 1 – Sisters of Nazareth, Derry/Londonderry

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Introduction

1 The Inquiry devoted Module 1 to the examination of evidence relating to two homes run by the Congregation of the Poor Sisters of Nazareth in Londonderry, namely St. Joseph's Home, Termonbacca, and Nazareth House in Bishop Street. These institutions were dealt with in the same module because there are a number of overlapping features in the manner in which they were run and other links between them although, as will be apparent from the remainder of this chapter, we have examined them separately. The Inquiry devoted thirty-nine sitting days to this module commencing on 27 January 2014, spread over ten sitting weeks from 27 January to 29 May 2014. During the ten sitting weeks, one of which (week 6) was a closed session, the Inquiry received oral evidence from sixty-two witnesses and received written statements from a further ten witnesses. The evidence of one other witness was not admitted. In addition to the oral and written evidence we have taken into account the detailed written and oral closing submissions made on behalf of fourteen individuals against whom allegations of abuse were made, and we also received written and oral submissions on behalf of the Congregation of the Sisters of Nazareth, the Department of Health, Social Services and Public Safety, as the successor department to the Ministry of Home Affairs and the Department of Health and Social Services, each of which had statutory responsibility for these homes during the period with which we are concerned. We also received oral and written submissions on behalf of the Health & Social Care Board, as the successor to the various local or statutory authorities which had responsibilities for the care of children in this area. We have considered all of this evidence and paid careful attention to the various written and oral submissions which were made to us, however in accordance with our general approach and our Terms of Reference, we do not propose to refer to each and every detailed allegation that was made, whether against an individual or either institution, although we have taken all of the evidence and the submissions into account. For simplicity's sake we shall refer in this chapter to St. Joseph's Home, Termonbacca as "Termonbacca" as this was the name by which it was commonly referred to by witnesses and officials alike. At this point it is appropriate to say something about the background of each of these institutions and how they operated.

Background

2 Nazareth House was the first of these institutions to come into existence. Its origin can be traced to a legacy from a Mrs. Watters, a native of Derry, to the then Roman Catholic Bishop of the substantial sum of £7,000. In 1892 the Bishop bought a property in Bishop Street and eight smaller houses in the same street for £3,360. The home was expanded in 1889 when some adjoining properties were purchased. As a result of an invitation from the Bishop, the Congregation of the Poor Sisters of Nazareth came to Derry in February 1892, and Nazareth House formally opened as a home for elderly and young people on 2 March 1892. Throughout the period with which the Inquiry is concerned, Nazareth House made provision for the care of both old people and young children, and the Sisters of Nazareth also ran a school for young children as part of the same site. Nazareth House ceased to be a home for children in 1998, and the old people's home which continued on the same site closed in 2012. The site still contains a primary school.

3 The main building comprised four floors with classrooms, bathrooms and playrooms on the ground floor. A nursery was located on the first floor; whilst the second and third floors contained dormitories for older children. The dormitories were intended to sleep up to forty children, and the children, including siblings, were separated according to age. The Foundation Book says that in 1956 the largest dormitory was divided into three small rooms, and in 1958 two large dormitories were divided into four small rooms. The home remained in this form until it was extensively modified in the early 1970s when the building was adapted to provide accommodation for family groups. This was brought about by the creation of separate apartments, each comprising bedrooms, sitting rooms, toilet facilities and small kitchens created by the conversion of the large dormitories. At this time the children continued to take their meals together in the common dining room. However, in the last years of its existence as a childrens' home the family units were further modified and upgraded to provide separate bedrooms, each containing a wardrobe and sink, as well as the installation of central heating and separate unit dining rooms so that all of the children in the home no longer ate in one large group.

4 Though it appears that Nazareth House could accommodate as many as 180 children up to the age of fourteen, for the greater part of the time with which the Inquiry is concerned it contained between 60 and 100

girls. When Nazareth House was formally registered as a children's home in July 1950 the Sisters of Nazareth declared that it would be capable of accommodating 180 children up to the age of fourteen, although, as stated above, the normal number appears to have been between 60 and 100, usually at the upper end of this range, and the Sisters of Nazareth have informed the Inquiry that throughout its existence as a children's home a total of 2,347 children were received into their care at Nazareth House.

5 A particular feature of Nazareth House was that until the late 1970s the individual sisters who looked after the children also taught in the school on the same site. As a result they had not only to perform their regular teaching duties, but they were also individually responsible for the care of a very large number of children outside school hours. This meant that they had to get the children up in the morning, prepare them for, and supervise, their breakfasts then get them out to school and spend the rest of the school day performing their teaching duties. Then in the afternoon and early evening they had to resume their duties in charge of the children, supervising them after school, getting them ready for bed and so on, although they were assisted from time to time by other sisters who had time to spare from their respective duties, whether as collectors or looking after the old people on the same site. They also were helped by older girls who continued to live on the premises after they had left the home. These girls would volunteer to help out with the sisters in the evening and supervise the younger children when the sisters were at prayer or having their own recreation time.

6 St. Joseph's Home, Termonbacca was founded in November 1922 when the Sisters of Nazareth purchased a substantial house and one hundred and ninety five acres of land situated in the town land of Termonbacca. Termonbacca is Irish for "a sanctuary for lame, crippled or poor person". From its inception the home was supported by the proceeds and produce of the farm, which was actively farmed by the Sisters. The original building was not large enough to house the number of boys who eventually lived there and as a result a number of extensions were added over the years. In 1926 two substantial iron huts were donated to the Congregation and placed on land behind the main house. These comprised a dormitory, bathroom and toilets, together with a dining area for twelve senior boys who were also engaged in working on the farm. When Termonbacca came into existence, and for a considerable period

thereafter, it was in a completely rural area somewhat remote from, although relatively close to, the city, until the creation of new housing estates in the adjoining Creggan area meant that the urban sprawl of Londonderry expanded almost to the home.

7 By the 1950s it had expanded in size and its stated capacity as a voluntary home was 92 boys. It remained purely a home for boys until a major change of direction was undertaken in the late 1960s when girls were admitted as part of family groups to Termonbacca. The Congregation has informed the Inquiry that 1,834 children were received into Termonbacca in the sixty years of its existence. The actual number of boys accommodated at Termonbacca was close to the stated maximum capacity throughout the 1950s and early 1960s, for example in 1953 there were 86 children[1] and in 1957 there were 92 boys.[2] However, in the early 1960s the pattern of care changed. Children were no longer admitted for their whole childhood, but they typically stayed at Termonbacca for a period of a few years or less. By the late 1960s the numbers being received into Termonbacca had almost halved and a major rebuilding exercise was embarked upon. This resulted in the construction of completely new family units with the conversion of the children's wings into three such units, each with a capacity of fifteen children with one sister in charge of each unit. Each of these units consisted of two or three bedrooms and the three new units, with a maximum capacity of forty five children, replaced what had hitherto been two large units accommodated in dormitories, each the responsibility of one sister. The fall in the number of children being admitted to Termonbacca by the late 1960s reflected a general move away from large institutions to the increased use of foster care, as well as a reduction in the number of children being placed voluntarily in the home. The construction of the new family units took some years to achieve and involved a total cost of almost £100,000 of which the Sisters of Nazareth raised more than half, with the remainder being provided by a government grant. We shall refer to this again later in this Chapter.

8 In summary, the roles of the two homes run by the Sisters of Nazareth in the Londonderry area changed dramatically between 1950, when Section 92 (1) of the Children and Young Persons Act enabled the welfare authorities to develop residential childcare services, and 1998, when the Nazareth House in Derry closed. By 1950 Termonbacca and

1 SND 5798.
2 HIA 1780.

Bishop Street provided approximately 200 places between them, and there was no other residential childcare provision. Although most of the placements in these homes in the 1950s were voluntary and there was no involvement on the part of the welfare authorities, it is clear that the authorities were highly dependent on the services provided by the Sisters of Nazareth and they would have been in dire straits if the homes had been closed or seriously reduced in resident numbers.

9 Throughout the United Kingdom the homes run by the Sisters of Nazareth were among the largest institutions, at a time when local authorities were opening family group homes for eight or ten children, with a scattering of larger homes for 20 – 26 children. The welfare authorities opened Fort James children's home with fifteen beds, and Mourne Drive family group home with six beds. In 1980 Harberton House opened with 20 beds (rising later to 25) to undertake the reception, assessment and treatment of children. Also within the Western Board's area, Coleshill children's home in Enniskillen had 26 beds. Some children were placed elsewhere in training schools or in homes in Belfast, but these were relatively few, and the welfare authorities liked to look on the residential services in the area as being self-sufficient.

10 Meanwhile the numbers of children in Termonbacca and Nazareth House were being reduced, partly on a planned basis with the introduction of smaller internal 'family' units, and partly because of decreased demand. As benefits were improved and less social stigma was attached to single mothers, fewer babies and young children were being received into care. The children who were being received into care tended to be older, many had been deemed in need of care and control and some displayed very disturbed behaviour. It is clear that the WHSSB increasingly used its homes for the care of such children and we saw examples of children whose behaviour could not be contained in Termonbacca and Nazareth House being transferred to statutory homes. By the time Termonbacca closed in 1982 and Bishop Street in 1998 these homes were seen as dated.

11 Since Termonbacca closed it has been owned and run as a retreat centre by the Carmelite Order of Friars. This Order had no previous involvement with Termonbacca and had no connection with the running of the property as a children's home, and since 1982 the Sisters of Nazareth have had no involvement with Termonbacca.

12 Although Module 1 was concerned with the allegations relating to Nazareth House and Termonbacca, these homes have to be viewed in the context of a third home run by the Sisters of Nazareth at Fahan, Co. Donegal, which was closely connected with both Nazareth House and Termonbacca. The house at Fahan was purchased by the then Roman Catholic Bishop of Derry, Bishop Farren, and was initially used to house 40 babies evacuated from Nazareth House as a safety measure during the Second World War. Bishop Farren's long-term aim was that it would be used as a mother and babies home: it was later used by the Sisters of Nazareth for that purpose for many years. Fahan received babies from mothers living in Northern Ireland, principally in the City and County of Londonderry, as well as children placed by families from Co. Donegal. In addition, another house in the grounds was acquired and was used as a holiday home for many years by the children of Nazareth House. For a significant period of time the house at Fahan kept babies until they were in or around two years old, many of whom were then transferred either to Termonbacca or to Nazareth House.

13 A significant number of the children admitted to both Nazareth House and Termonbacca over the years came from the Republic of Ireland, principally from Co. Donegal. Although many of those children were the children of mothers resident in Northern Ireland who chose to place the children in Fahan, the majority of the children in respect of whom information has been provided to the Inquiry by the Sisters of Nazareth appear to have been born in Co. Donegal. Figures relating to Nazareth House provided by the Congregation indicate that 88 children, all but three of whom were girls, came from Co. Donegal up to 31 December 1989.

Number of children	Born
45	before 31/12/1949
24	between 1/1/1950 and 31/12/1959
14	between 1/1/1960 and 31/12/1969
2	between 1/1/1970 and 31/12/1979
3	between 1/1/1980 and 31/12/1989

14 A similar pattern is evident in relation to admissions to Termonbacca. Seventy-five children were admitted from Co. Donegal: seventy-one boys and four girls.

Number of children	Born
37	before 31/12/1949
14	between 1/1/1950 and 31/12/1959
23	between 1/1/1960 and 31/12/1969 (including 3 girls)
1	(girl) born in 1971

15 The Government and the relevant local authorities were well aware at the time that children were coming from Donegal. In January 1957 Eddie McAteer, a nationalist Member of Parliament at Stormont, wrote to the County Londonderry County Borough Welfare Committee in relation to both Termonbacca and Nazareth House. In these letters he pointed out that of 87 boys in Termonbacca, 21 (24%) had been born outside Northern Ireland, and of one hundred and fifty seven girls in Nazareth House, 35 (22%) had been born outside Northern Ireland. *The Report of the Northern Ireland Child Welfare Council for 1956 to 1959* also drew attention to this, saying that of the 84 children in voluntary homes born in the Republic of Ireland, 63 of them (75%) were concentrated in two Roman Catholic Homes in Londonderry (i.e. Nazareth House and Termonbacca). The report continued:

> "This transfer to Northern Ireland at the age of 3 years of children born in Eire represents the continuation of the long-standing tradition of sending deprived children from the babies' home in County Donegal to the children's homes in Londonderry which are run by the same organisation."[3]

16 Until the early 1970s both Nazareth House and Termonbacca received the great majority of their children as the result of parents or other relatives placing children with them voluntarily, and so the children in question were not officially in care so far as the relevant local authority county or county borough welfare committee was concerned, and so were not regarded by the welfare committees as their responsibility. In the 1950s the principal reason why children were placed in these homes, as in many other voluntary homes in Northern Ireland, was because they were illegitimate. For example, the Northern Ireland Child Welfare Council report already quoted observed that of the six largest

3 *Report of the Northern Ireland Child Welfare Council 1956-59*, page 21 paragraph 84.

voluntary homes in Northern Ireland, two out of every three children were illegitimate, and in Nazareth House 57.7% were illegitimate and in Termonbacca 60% were illegitimate (although these figures were considerably lower than several other houses in Northern Ireland).[4] Other reasons why children were placed in homes were because they may have been the responsibility of a single parent, a widow or widower, who could not cope, or because the overall family circumstances were such that the family was unable to cope with their children, possibly for financial or health reasons. Such children were often from large families, and there were many examples of groups of siblings being admitted to residential care at the same time. However, older and younger siblings at times remained at home, and this made it difficult for the children admitted to care to understand the rationale for their placement.

17 In a great many cases the introductions of the children to the home in question were made by parish priests or other religious. The figures already referred to the Inquiry by the Sisters of Nazareth indicate that of the 67 children admitted to Termonbacca from Co. Donegal, all were admitted on the recommendation of Catholic clergy. Of the 88 children admitted to Nazareth House from Donegal, 25 were recommended by priests, and five by female religious such as the Sisters of Mercy at Stranolar, Co. Donegal. These figures are not surprising because it was extremely common in the Roman Catholic community of the time for the mother, father or other relatives of a child to seek the advice of their parish priest, as was pointed out by Bishop Daly in his evidence to the Inquiry. The Child Welfare Council in its 1956 to 1959 report touched on this when it said:

> "The choice by clergymen of voluntary homes is explained partly by their concern that the child's religious upbringing might not be so well secured in the care of a welfare authority as in a voluntary home which is run by a religious community or by an organisation with a religious connection, and partly by the determination of the parents and relatives, whom the clergymen are trying to help, to seek the privacy of a voluntary home for an illegitimate child."[5]

18 Although until the late 1960s or early 1970s the great majority of children in Nazareth House and in Termonbacca were placed voluntarily, by the late 1950s there were a number of children placed in these

4 Page 5 paragraph 11.
5 Paragraph 79.

institutions by local county welfare committees. In September 1960 five girls had been placed in Nazareth House by County Londonderry Welfare Committee,[6] and a small number of children had been placed in both homes by Co. Donegal County Council as the welfare authority there. The figures provided to the Inquiry by the Sisters of Nazareth indicate that six were placed in Nazareth House by the Co. Donegal welfare authorities. Although there are no overall figures for the position at Termonbacca, fragmentary pieces of documentary evidence support the oral evidence of some witnesses who say that they were placed there by the Co. Donegal welfare authorities. For example, there is a record that £1 per week was paid for HIA 46 upon his admission in 1955,[7] and evidence given to the Inquiry in closed session stated that the Co. Donegal Welfare Committee contributed £24 per annum, and a clothing allowance, to the upkeep of HIA 68 who was placed in Termonbacca in November 1950.

19 It seems that it was not until the late 1950s that local welfare committees in Northern Ireland started to place children in Termonbacca[8] on a regular or substantial basis. By the end of 1959 Londonderry County Borough Welfare Committee had placed two children in Termonbacca; this increased to three by the end of 1961.[9] By 1963 there were four children, two from Londonderry County Borough, and two from County Tyrone, County Welfare Committees,[10] and by the end of 1963 out of 87 children in Termonbacca, eight had been placed by welfare committees.[11]

20 The placing of children in care in both institutions by local welfare committees and their successors increased in the 1970s until all the children in both had been placed in care by social services, but were being cared for by the Sisters of Nazareth. Throughout the period during which children were placed in care by local welfare authorities in this way, a charge was made by the Sisters to the authority concerned, and we will consider this later in this portion of the report when dealing with funding. For present purposes it is sufficient to state that the amounts charged for such children were always modest compared to the amounts charged by and allowed by local authorities, and by

6 SND 9211.
7 SND 1350.
8 HIA 1861.
9 HIA 1856.
10 HIA 2685.
11 SND 7804.

central government, to statutory homes in the public sector. This is a matter which we consider in greater detail later in this chapter, but in the early days the Sisters were solely dependent upon their own financial resources, and even when the local welfare authorities were placing children in either Nazareth House or Termonbacca, the amounts were not particularly substantial so far as the overall income of either institution was concerned.

21 At both Nazareth House and Termonbacca for the greater part of the period within the Inquiry's terms of reference the position was that the Sisters of Nazareth at both institutions were almost completely dependent upon the goodwill and extremely generous practical and financial support given to both homes by members of the Roman Catholic population in the City of Derry, in Co. Londonderry and in Co. Donegal. This support manifested itself in a number of ways. The Sisters at Nazareth House for many years carried out regular collections throughout the streets of Derry and in country districts. As the number of sisters available to carry out collecting diminished parish collections were instituted instead. Many of the witnesses who gave evidence to the Inquiry were fulsome in their praise of the generosity of the local population and of many local businessmen and business concerns. It is important that the allegations against the Sisters which we have to consider are viewed against the background of considerable poverty in the community from which they drew their financial and practical support. Nazareth House, in particular, was dependent to a very considerable degree on the proceeds of these collections, although it appears that at least by the late 1960s or early 1970s, if not before, it was the practice of Nazareth House to provide substantial proportions of the money it raised by collections to its sister houses at Termonbacca and Fahan. That at least was the evidence of SR 52 who served in Nazareth House from 1967 to 1975. She said[12] that the Saturday and Sunday collections always went to Termonbacca and Fahan, and that £1,000 per month went to each. As will become apparent when we examine the question of funding, both Nazareth House and Termonbacca received little financial support from either central or local government until some capital grants were provided in the late 1950s. A greater degree of capital grant funding was made available in the 1960s and 1970s, but almost to the end of the period covered by our terms of reference both

12 Day 29 pp. 91 and 92.

institutions had to grapple with constant problems in obtaining sufficient funds to meet their day to day running costs.

22 We refer to these matters at this stage to emphasise that whatever criticisms may or may not be legitimately leveled at the manner in which the Sisters of Nazareth discharged their obligations to the children in their care in both Nazareth House and Termonbacca, throughout this time the individual sisters, and the Congregation of the Sisters of Nazareth in general, had to struggle with very limited financial resources and had to do the best they could within those resources. The sisters who gave evidence before us repeatedly expressed their appreciation of the financial and material help provided to them by the people of Derry and County Londonderry, as did a number of those who were placed in both institutions. The practical and financial help given by members of the St. Vincent De Paul organisation together with generous donations from individual benefactors over the years, and frequent gifts of material and money by local businessmen and firms such as Desmonds, and the kindness extended to individual children by working people in businesses such as Woolworths, must be acknowledged. Without such generous help the Sisters of Nazareth could not have looked after these children at all. In the course of receiving evidence we came across many and varied examples of good practice, including holidays and day trips to the seaside, the arrangement of large numbers of summer placements, visits by St Vincent de Paul, choirs (including success in public competitions), the Termonbacca band, instances of educational encouragement for some children, finding jobs and accommodation on discharge for most witnesses, dealing with the IRA during the Troubles, the appointment of a social worker at Termonbacca to improve collaboration with the welfare authority social workers and attempts to improve aftercare.

23 It is also right that we acknowledge that many witnesses who spent their childhood in either institution and gave evidence to the Inquiry recognised that individual sisters devoted their lives to looking after children, and made many material sacrifices in order to follow their vocation (or apostolate as the Sisters refer to their calling) to serve others. Whilst many were bitter about the way they were treated, some accepted that even those who they say ill-treated them displayed kindness on occasions. Indeed, many who made allegations of various forms of ill-treatment by named or unnamed sisters acknowledged that other named sisters and unnamed sisters were kind and affectionate

towards the children in their care. Many of the witnesses who spent most of their childhood in either institution (12.9 years on average until 1963 when stays became shorter), regarded the sisters as their family, and kept in touch with individual sisters long after they left either Termonbacca or Nazareth House, including in some cases those sisters against whom they now make allegations of wrong-doing.

24 A number of witnesses came forward during the course of Module 1 to give evidence contradicting allegations made by other witnesses because they wished to publicly put on record that they regarded the evidence given by others as inaccurate and unjustified slurs on the Sisters of Nazareth as a whole and on individual sisters. One witness came from Australia at his own expense for that purpose, and one from England, to give evidence in relation to Termonbacca, and two came forward for the same purpose in respect of Nazareth House. We have taken their evidence into account when reaching our conclusions, although it has to be said that in a number of instances parts of the evidence of those witnesses corroborated some of the allegations made by others, as will appear in later parts of this chapter.

25 Although the individual houses were in what was described to the Inquiry by the Congregation as a "semi-autonomous" relationship with the mother house and the central administration of the Congregation, each home had some connections with, and attempted to help, the other. Termonbacca was supported by its substantial farm, although this does not always seem to have been profitable, and we accept that the Sisters at Termonbacca provided produce to the Sisters in Nazareth House in return for bread baked by the Sisters in Nazareth House. Mention has already been made of the share of the collections which was apparently passed to Termonbacca by Nazareth House. Nevertheless each institution operated as a separate organisation in financial terms, and we shall deal with the implications of this later in this chapter.

26 The day-to-day functioning of both Nazareth House and Termonbacca was of course marked by the Roman Catholic ethos which each sought to observe and promote. Each sister had taken vows of poverty, chastity and obedience, and obedience was therefore one of the central tenets of the Congregation. This naturally led individual sisters to show obedience to those placed in authority above them, and, we are satisfied, sisters expected it of the children towards them. Understandably, in accordance with the widespread attitudes of many in Northern Ireland

society at that time (whether Roman Catholic or Protestant), individual sisters and the Congregation as a whole held very strong views on the sinfulness of sexual activity outside marriage, as well as espousing virtues such as hard work and humility.

27 We have already referred to the burden placed upon individual sisters who were expected to look after the children in their care, as well as teach them in Nazareth House, and a similar burden was placed upon individual sisters in Termonbacca. It was not until the change that was made to bring in small family units in the late 1960s that appreciable numbers of sisters were assigned to look after the older children in Termonbacca. Figures supplied to the Inquiry by the Congregation indicate that in 1950 only one sister was in charge of nearly ninety children, and one sister was in charge of the babies. In 1951 there were two sisters in charge of the children and one in charge of the babies, but in 1952 and for each year thereafter, up to and including 1957, only one sister was apparently allocated to look after all of the children other than the babies in those years. In 1958 there were two, in 1959 there was one, and from 1960 onwards there were two sisters, each of whom took responsibility for up to forty children. One of the allegations made to us relates to the extent to which younger children at Termonbacca were left in the care of older children. Several sisters denied that this happened. We do not accept their evidence on this, and we are satisfied that there was considerable reliance by sisters on older children supervising younger children. This was inevitable. In the life of each house provision had to be made for the spiritual life of the Sisters, which involved time for prayer and attendance at Mass. Whilst this provided a degree of respite for the individual sisters, we have no doubt that this brought about a situation where younger children were left under the supervision of older boys, something which we later examine in detail and which we believe was a wholly unsatisfactory state of affairs.

28 Another effect of the low staff numbers in the 1950s and 1960s was that in order to cope, the Sisters needed children to conform and be biddable, even if that at times entailed repressing them. The Sisters appear to have had difficulty in dealing with certain behaviour such as running away or “escaping”, as it was termed (which does not appear to have been frequent), serious disobedience or aggressive behaviour towards sisters. At times this appears to have led to loss of temper, inappropriate control measures, or threats of transfer to another institution.

Part One:

Termonbacca

29 The number of complaints made to us, and the number of witnesses from whom we received evidence either in oral or written form relating to Termonbacca, was substantially greater than the number who made allegations in relation to Nazareth House, and we therefore propose to deal with Termonbacca first. We will consider the allegations made to us under the various headings which comprise our definition of abuse, but before doing so there are a number of general observations which it is appropriate to make at this point. The number of complaints which we received, and the individual allegations, are relatively consistent in terms of their distribution over the individual decades from the 1940s until the closure of Termonbacca in 1982. It is not possible to identify in every instance an allegation to a particular year, because a number of those who gave evidence to us were unable to be so precise, nor is it possible to divide the complaints by decades because individual witnesses may have spanned more than one decade. However, allegations were made by fourteen people who entered Termonbacca in the 1940s, or in one case from 1939; fourteen made complaints relating to the 1950s, and eighteen made complaints relating to the 1960s. The number reduced somewhat thereafter because thirteen made complaints relating to the 1970s; and seven who were still in Termonbacca when it closed in 1982 made complaints.

30 As these broad figures demonstrate, some of the allegations go back sixty years and more. Although there are some facts which can be established with some degree of accuracy as to when individual sisters were in Termonbacca, the records produced by the Sisters of Nazareth were not always reliable. Sometimes it is not apparent when a particular sister came or left during the year in question, and in some instances the recollections of individual sisters did not tally exactly with the rather elementary records which the Congregation appears to have kept as to the whereabouts of individual sisters at any given time. There are a number of instances where contemporary records may confirm or disprove the recollection of witnesses, but unfortunately these are relatively few and far between. Ultimately in a great many instances the Inquiry has had to make a decision as to whether individual allegations or categories of allegations have been established on the basis of our

own assessment of the reliability of individual witnesses, and in many instances it came down to whether we believed the evidence of one individual when compared to another.

31 In making these decisions we have of course been alert throughout to the risk that some witnesses may not be reliable in their recollections of what they say occurred. The most obvious factor in this context is the passage of time which has elapsed since so many of the witnesses were children. Another possible factor that has to be considered is that some witnesses may have been motivated by hope of financial gain. Another factor that has to be considered is whether some may have been influenced in their recollections by discussions which they have had with others over the years; or, as was suggested by the final submissions on behalf of the Congregation, by knowledge of findings of the Ryan Commission in relation to allegations that were made in relation to religious institutions in the Republic of Ireland. We have considered the detailed submissions that were made on behalf of the Congregation and on behalf of individual sisters. We have also considered the submissions made on behalf of those individuals who are themselves alleged to have been abusers. They were alleged to have committed abuse as older children, or as former residents, or as employees of the Congregation (and some fall into more than one of these categories). On their behalf, submissions were made that some allegations were at best mistaken or unreliable, or at worst were fabricated.

32 In this context there are a number of observations of a general nature which we wish to make in response to both general and specific submissions made to us in relation to the evidence of witnesses in this module. Some of those who are vocal in their condemnation of the behaviour of either individual sisters or the Congregation as a whole accepted that they kept in touch with individual sisters by letter or postcard, by making visits to Termonbacca from time to time, either on their own or with members of their families, or by attendance at functions connected with Termonbacca in some way, such as weddings of former residents, reunions with former residents and sisters, or funerals of individual sisters. A common response on behalf of those against whom allegations have been made is that such contact was inconsistent with abuse having been inflicted on the person remaining in contact, because if the individual concerned had been abused in the manner he or she alleges they surely would not have kept in contact

with the sister or sisters concerned; contact which was frequently on very friendly terms. We reject that as a general proposition. In the case of both Termonbacca and Nazareth House the home and those who lived and worked in it was the only family which many of the witnesses knew. In a great many instances they had effectively been abandoned by their families, or were unable to establish contact with their surviving parents or siblings in later years until they themselves were well on in years. We accept that many who suffered abuse do not find it easy to speak to anyone about such matters. Indeed, for a variety of reasons such individuals often continue to have what appear to be, or in some instances may in fact be, friendly relations with those whom they now say abused them. It has been accepted in countless criminal trials that such apparently friendly relationships are not inconsistent with an individual who now comes forward and complains of having been abused in some way as a child having actually experienced that abuse, because victims of abuse frequently have an emotional or psychological dependence upon their abuser, even if that person is a member of their family or someone else, such as a friend, with whom they come into contact on a frequent basis later in life.

33 When reaching our conclusions as to whether there were systemic failings, we have of course had to form our own conclusion as to the veracity and reliability of the evidence given by individual witnesses. However, in reaching our conclusions we have not been solely dependent on our own view as to whether we prefer one person's unsupported word against the denials of those who are alleged to have inflicted abuse. This is because a number of pieces of evidence emerged from the testimony of individuals who are not themselves applicants to the Inquiry, but who came to give evidence to the Inquiry. Sometimes they did so in response to allegations made against them to which the Inquiry considered they should have the opportunity to respond, or because in a small number of cases the individuals themselves came forward to offer their testimony to the Inquiry. In some instances, material emerged from the testimony of such individuals which supported the evidence of applicants.

34 Three examples in relation to Termonbacca will suffice to make this point. One of the most significant allegations concerns the way in which many sisters treated those who had the misfortune to be regular bed wetters in their childhood. Those sisters who gave evidence to us denied that the allegations which we shall consider in greater detail in due course

were well-founded. However, SND 76 was one of those who came to give evidence in support of the Sisters. He said that during his time in Termonbacca in the late 1960s a bucket was placed in the dormitories for the boys to urinate into at night, and this allegation had also been made by HIA 98, who did not give oral evidence but submitted a written statement which we received. The other example relates to the allegations of sexual abuse. SND 48 was one of those witnesses alleged to have committed abuse. His evidence was that during his time as a child in Termonbacca he was aware of boys doing sexual things to other boys, and he conceded that he may have done so himself. SND 23 not only admitted engaging in consensual sexual activity with other boys when he was twelve to sixteen, but accepted that he was aware that former residents and adults with access to Termonbacca had engaged in sexual activity with boys who were still resident there. Indeed he alleged that he himself had been abused by an adult who visited Termonbacca on a weekly basis.[13] We consider that although there are only a small number of such instances, they are of considerable significance because they come from witnesses who were not applicants to the Inquiry. That they conceded that such events occurred provides significant support for the similar accounts of those who are alleged to be unreliable witnesses.

35 A great many of those witnesses who gave evidence to the Inquiry as applicants impressed us with their evident sincerity, even if they may have been mistaken in some details. We consider this to be understandable because of the passage of time, or their lack of appreciation of the significance of events at the time when they were children, or their failure to report the abuse to those in authority at the time. A common statement was that the individuals concerned were giving evidence not only so that their own experiences could be placed before the public, but so that the voices of those who had died, often tragically as young men, and who therefore did not have the same opportunity to describe their unhappy lives, would have said had they been able to give evidence. Many of the applicants plainly found the experience of having to recall the events they described deeply upsetting, and in a great many instances we are satisfied that the individuals concerned were doing all that they could to give an accurate account of their experiences. They may not always have been accurate, and that is only to be expected because of the passage of time, but they were sincere.

13 SND 15883-15890.

36 Finally, it is not just our own conclusion that many of the allegations made to us were well-founded. Although it was not conceded on behalf of the Congregation that every allegation was well-founded, nevertheless when Sister Brenda McCall gave her evidence on behalf of the Congregation she made it clear that the Congregation accepts that there were abuses, although she did not concede that every individual allegation was well-founded. On 20 May 2014 there was the following exchange between Counsel for the Inquiry and Sr Brenda:

> **Q.** "[Counsel] if I might explore that somewhat with you, Sister, can I ask you how you accept that? Where do you say - where does the Congregation accept that the standard of care was not at the appropriate level?
>
> **A.** Well, I think, having listened to evidence given here, which was very shocking and harrowing for us, we must accept at certain times by certain sisters things were just not right."[14]

She was then asked:

> "…in general terms does the Congregation accept that members of the Congregation did physically assault children in their care?
>
> **A.** Unfortunately, yes, I would accept that.
>
> **Q.** And equally older boys, as we have heard, and ex-residents, it is accepted by the Congregation there were physical assaults committed by those people?
>
> **A.** Yes, yes.
>
> **Q.** And indeed the lay staff who would have been employed by the Congregation, whether in terms of volunteers who were coming in or in terms of employees, is it accepted that there was also physical assaults committed by those people?
>
> **A.** In some instances yes."

Sexual abuse

37 There were a very large number of allegations that sexual abuse was perpetrated against young children. We are satisfied that repeated episodes of non-consensual sexual activity were perpetrated by older boys against younger boys. The older boys were often referred to by the witnesses as "seniors". We have concluded that almost all the

14 Day 36, p. 30.

episodes which we believe did occur did so: at night when children were in the dormitories and were meant to be asleep; or when the sisters were at prayer; or in locations, whether on the farm or elsewhere within the buildings at Termonbacca, where the perpetrators believed that they would not be seen by others in authority. We accept that the offences which occurred ranged from masturbation to inflicting oral sex on younger children or requiring younger children to perform oral sex and included episodes of attempted buggery and actual buggery.

38 We also accept that in later years when girls were admitted to Termonbacca two girls were subjected to episodes of digital penetration by boys in the home.

39 There were many allegations where it is alleged that adult males repeatedly perpetrated non-consensual sexual behaviour on younger children. These males fell into one or both of two separate categories. The first was that there were a number of male employees who worked on the farm or around the buildings. Whilst a great many of the applicants spoke very highly of the late Robert Ennis, and referred to him as a very fair and supportive man, other employees were identified to us as alleged abusers. The other category of perpetrator consisted of those who had been children in Termonbacca themselves and who continued to return to the premises after they had left as adults. For convenience these are referred to as ex-residents. A number of sisters gave evidence denying that ex-residents were able to have access to the premises in a fashion that would have allowed them to commit offences of this sort. We reject their evidence, not least because a number of those who gave evidence to the Inquiry who were not applicants conceded that they themselves had been abused by older men who returned to the premises.

40 There were a number of instances where it was alleged that individual sisters came across unmistakable evidence of improper physical activity between older boys and younger children, and a number of the witnesses said that they reported episodes of sexual abuse to individual sisters. In almost every case where this was done, the evidence of the individual concerned was to the effect that no action appeared to have been taken against the perpetrator(s). Indeed on a number of instances the witnesses claimed that the response of the sister was to say that they did not believe the allegation, and the child was often physically or verbally chastised for making such an allegation.

41 We accept that there is credible evidence that these reports were made on many occasions, and have concluded that these reports should have alerted both the individual sisters and the Congregation as a whole to the substantial risk that existed in Termonbacca that boys would be subjected to sexual abuse by other boys. Effective precautions should have been, but were not, put in place to prevent the sexual abuse taking place. Not only are we satisfied that a number of allegations were made to the sisters which should have put them on notice of this danger, but the wide disparity in ages between many of the boys itself created an obvious risk of improper sexual advances and sexual exploitation of younger boys by older boys.

42 In reaching this conclusion we have had regard to the evidence of many of the social workers who gave evidence to the Inquiry that peer sexual abuse was not on the radar of those active in the social work field until very late in the period covered by the Inquiry's terms of reference. Nevertheless, for decades it has been a recognised problem in male communities involving children that various forms of sexual abuse can be inflicted by older boys on younger boys. It may not have been as widely recognised or publicly discussed at that time as it has become in recent times, but we are in no doubt that the collective experience of the senior members of the Congregation should have alerted them to this risk, just as they were alert to the risk of older boys bullying younger boys. As SR 2 put it:

> "[Bullying] was something you were always looking out for to protect the smaller children or even boys of the same age, because some were more powerful than the others. You had to watch out for the vulnerable ones."

She also conceded that the sisters were aware of the potential for the children getting into sexual exploration at that age.[15] With that knowledge the Sisters should have taken steps to instruct sisters in the risks that could arise, and devised methods that would have at least reduced the likelihood of such abuse taking place.

43 In addition to allegations of sexual abuse by older boys, ex-residents and employees, sexual abuse by three named and two unnamed priests have been made. We have considered these carefully, and taken into account both the oral evidence from the witnesses concerned and the

15 Day 33, p. 103.

documentary material made available to us by the PSNI and the Roman Catholic Diocese of Derry. Whilst we are not persuaded that each of the priests identified to us did commit acts of sexual abuse in relation to children at Termonbacca, we do accept that at least three priests, one of whom is deceased and two of whom cannot be exactly identified, may well have committed serious sexual offences in relation to children whilst those priests took advantage of opportunities presented to them when they were in Termonbacca to hear confessions or celebrate Mass.

44 Although we accept that there were episodes of serious sexual abuse in the form of masturbation of the children or attempts at buggery, it does not automatically follow from this that there was a systemic failure on the part of the Congregation to prevent such sexual offences being committed against children in their care. We say this because in any form of religious or other institution of a similar type at that time a great many people regarded it as simply inconceivable that individual priests or clergy, of whatever denomination, could abuse what was regarded by their fellow communicants as the sacred trust which they held as ordained clergy, or as people who were to be ordained. Sadly it is now only too well known that many Roman Catholic priests have abused their position to inflict grave sexual crimes against children, as indeed have clergy from other Christian denominations. However, it is our view that unless the Congregation in these particular instances, or an individual sister, had reason at the time to suspect that the priests in question were capable of committing these offences it could not be said to amount to a systemic failure on the part of the Congregation to prevent such abuse, because at that time neither the Congregation, nor the vast majority of other people, could have conceived that a priest would behave in that way. Were we to conclude that precautions which would now be regarded as appropriate, or a failure to recognise danger signs which would now be realised to exist, should have been taken account of by the Sisters of Nazareth at the time that these matters occurred, that would be to require the application of present day standards in the light of present day knowledge to a different time when the requisite knowledge was not as widespread as it now is.

45 There were also two instances where sexual abuse of children is alleged to have been perpetrated by females in Termonbacca. One of these relates to allegations which were made by HIA 125 against a sister identified as SR 5. It is alleged that the sister in question bathed him

and two other boys when he was about fourteen over a period of some three weeks or so, during the course of which the sister is alleged to have touched the genitals of the boys. We accept that there may have been an incident when some teenage boys were supervised whilst they were being bathed, although we are not persuaded that any contact with the genital areas of the boys concerned has been shown to have been for a sexual motive. On balance we consider it more probable that such actions were properly carried out to ensure that the teenage boys were washing themselves thoroughly at the time. That is not to say that such action would have been wise, because plainly it would not have been.

46 The second episode related to events described by HIA 46. As he said that he was five or six at the time, if his recollection is accurate that would mean that the incident he described occurred around 1957 or 1958. He was unable to recall whether the female in question was a sister or a lay staff member, but as the Congregation has informed the Inquiry that from the best of their records there were no lay staff employed at Termonbacca before 1962, if this episode occurred as alleged by HIA 46, it must have involved a sister. Although the incident he described where the female attempted to achieve sexual gratification by placing the penis of such a small child against her vagina appears improbable, it was described in considerable detail by the witness, and on balance we accept the truthfulness of his account and that this episode occurred. As such it was plainly an episode of sexual abuse, however it was a one-off episode by an individual in a position of trust, and as such we consider that such an abuse of trust was almost impossible to prevent. For that reason we do not consider that this episode amounted to systemic abuse, although it was a form of sexual abuse.

47 A number of complaints were made that some sisters had a practice of publicly inspecting the underwear of the children, and it seems from the descriptions of the witnesses concerned that the sisters were seeking to identify signs of sexual activity by the boys concerned resulting in the emission of semen on the underwear. We accept that such inspections were carried out, and were carried out in an insensitive and public fashion. The manner in which the inspections were carried out amounted to a form of sexual and emotional abuse. In addition, verbal and physical abuse by sisters followed if staining was found. Other witnesses complained that pockets were sewn up to ensure that

boys did not fiddle with their genitals. We consider that actions such as these were a manifestation of the inability of the Sisters to cope with issues of sexuality with young people.

Physical abuse

48 In his evidence to the Inquiry HIA 69 alleged that SR 6 assaulted him on various occasions, including beating him with the flex of a kettle.[16] The WHSSB records confirm that HIA 69 alleged to SND 484 who was his WHSSB social worker that SR 6 caught him by the throat on one occasion. She spoke to SR 6 who accepted that she had done so, saying that he had been quite insolent to her and that she had lost her temper with him.[17] HIA 69 was moved to a different section in Termonbacca. In her evidence on Day 23 SND 484 explained that whilst such an incident would be dealt with differently today, at the time there may have been no further action because the matter had been brought out into the open and dealt with by HIA 69 being moved to a different section where he would be under the supervision of a different sister.

49 A significant feature of the allegations made to us in Module 1 concerned allegations that there were many instances where unidentified sisters, and a number of sisters who were identified, resorted to frequent, severe and wholly unjustified physical chastisement of children. The allegations ranged from beating with whatever implement in the form of a chair leg or an electric flex came to hand; the practice of "knuckling", that is hitting a child on the head with the knuckles; or striking the child on the head with a bunch of keys, as well as other forms of blows with hands, or in some instances feet. Several sisters gave evidence to us including a number of those against whom such allegations were made. Although in almost every instance any form of physical chastisement or attack was denied by the surviving sisters who gave evidence, nevertheless we are satisfied that there was a large body of credible evidence provided by many of those who gave evidence of persistent and widespread resort by both named and unidentified sisters to a practice of severe, frequent and wholly unjustified physical chastisement of children which in some instances involved severe beatings. These practices may well have been unlawful in some instances as going beyond what was permitted by adults in loco parentis of children, and in any event was behaviour

16 Day 17, p.86.
17 SND 2231.

which was completely against the principles of the Congregation. As long ago as 1897 the General Chapter of the Congregation decided that children must not be severely punished,[18] and Sister Brenda McCall accepted that it was part of the ethos of the Congregation, and that "..the Sisters themselves knew that the Congregation didn't accept corporal punishment of any kind."[19]

50 We accept that there were occasions when individual sisters lost control of themselves to such an extent that they used their limbs, and resorted to whatever object was to hand, as weapons against the children. We further accept that these assaults were random, frequent and created a pervasive atmosphere of fear on the part of many children, making them reluctant to complain to anyone in authority about sexual or physical ill treatment by anyone, whether other boys or lay or clerical staff, lest they themselves received a beating as a result of their complaint. Even leaving aside the more extreme forms of beatings, which we accept occurred on some occasions, we are satisfied that the use of excessive chastisement was not merely a reflection of the widespread resort to such behaviour that was common in some homes, schools and other sections of society in Northern Ireland at that time, but was part of a deliberate practice by many sisters to maintain strict discipline, often by a single sister who was responsible for up to forty boys at a time, and thereby keep control of a large number of boys, some of whom were approaching manhood and strong young men.

51 In addition to allegations of beatings administered by nuns, there were many complaints to us of beatings administered by "charge boys" or "seniors", older boys who were acting as some form of informally appointed or recognised prefect. Such unusual terminology is itself an indication of such a practice. A common theme of such accounts is that beatings were administered for perceived offences such as not cleaning floors properly (a particular source of complaint), or to enforce discipline. In one instance it was asserted that a sister said "put some manners in him", a remark which clearly implied that the use of force would meet with the approval of the nun concerned.[20] There was also a certain amount of straightforward bullying.

18 SND 094.
19 Day 36, p. 10.
20 HIA 351 in closed session on Day 1, 26 March 2014.

52 We consider it noteworthy that some ex-residents, who were not applicants to the Inquiry, in their evidence corroborated allegations of beating and bullying by older boys. We recognise that some of the allegations may be exaggerated, but we are satisfied that there remain many credible allegations which lead us to conclude that this occurred on a widespread scale. We further consider it likely that at least some of those sisters who themselves resorted to physical chastisement of a severe and persistent nature were aware that "seniors" were also engaging in such behaviour, or at least suspected that it was occurring and did nothing to prevent it, because they wished to encourage by turning a blind eye to such actions by older boys in order to maintain discipline over the large number of children who they had to supervise.

Emotional abuse

53 We have defined emotional abuse as improper behaviour which undermined a child's self-esteem and emotional wellbeing. Four principal forms of emotional abuse emerged from the evidence placed before us. The most common complaint was of the way children of all ages, some of whom were very young, who wet their beds, or sometimes wet their clothes, were treated by sisters. It was alleged that sisters would beat the children concerned; that on occasions they were beaten on the soles of their feet, and that seniors also would beat children who had wet their beds. A particularly common and serious allegation was that bed wetters were made to stand with the wet sheets over their head, and then made to parade to the bathroom with these wet sheets over their head. A related allegation was that they were made to stand with the wet pants over their head if they had wet their clothes. It is alleged that bed wetters were often made to sit in the bath together, or were made to change straightaway into dry clothes without being washed and so smell of urine all day. One piece of evidence which we regarded as particularly striking in this context was the evidence to which we have already referred of one witness who gave oral evidence to the Inquiry, supported by one who did not, that in an attempt to resolve the problem of bed wetting in the 1960s a bucket was placed by the sisters in the middle of dormitories at night into which the boys were required to urinate to ensure they did not wet their beds. Given that there were bathrooms with toilets nearby we found this a revealing precaution, and a practice which was degrading and indefensible.

54 Despite the denials by individual sisters that these practices occurred we consider that there is overwhelming and credible evidence that the attitude of many sisters towards bed wetting was backward, extremely unsympathetic, and harshly punitive throughout the 1940s, 1950s and 1960s, although the scale of the problem may have abated to some extent once the boys moved from the dormitories into the new build with the smaller units that were completed by the early 1970s.

55 Bed wetting can be a difficult problem for any institution with a large number of unhappy children to deal with. There was evidence that the sisters tried to deal with bed wetting in a number of ways, such as placing mackintosh or rubber sheeting under the sheets, or, as was said on one occasion, putting the end of the bed up, apparently in the belief that this would reduce the problem. There is no evidence to suggest that the sisters, whether individually or as a whole, at Termonbacca understood the problem of bed wetting or how to deal with it. This was despite the fact that in 1952 the Ministry of Home Affairs sent to every voluntary home in Northern Ireland[21] a memorandum prepared by the Home Office in England on *Conduct of Children's Homes*.[22] The 1952 memorandum contained much wise advice on how to deal with bed wetting at paragraphs 23 and 24 which, because of their importance, we set out in full below:

> "Bed wetting cannot be attributed to any one cause; if effective help is to be given, the child must be studied as an individual. The trouble may be due to an organic cause, to delay in learning bladder control, or to emotional disturbance due to loneliness, a sense of being left in strange surroundings, or of not being wanted. A feeling of hopelessness about the habit may cause it to persist. A child who persistently wets the bed should be seen by the medical officer so that he can advise on treatment or, if necessary, refer the case to a hospital or child guidance clinic. Understanding and consideration on the part of the staff are of the first importance. Bed wetters should not be separated from other children, and members of the staff dealing with the child or with the wet bed should proceed in a matter of fact way, and should never exhibit impatience, disgust or anxiety. Mackintosh sheets should be used only when necessary, when they have to be used, a thin blanket should be placed between

21 SND 13482.
22 SND 13483.

> the mackintosh and the bed sheet. Sheets should always be changed after being wet. Bed wetters should not be required to wash their sheets. There is nothing to be gained by restricting drinks unreasonably, but it is undesirable that any child should drink large quantities late in the evening. There should be easy and lighted access at night to a lavatory, and where necessary the children should have their own chamber pots."[23]

56 Only one of the sisters who gave evidence had any knowledge of this guidance, despite it being circulated to all voluntary homes with the request that everyone relevant should be made aware of it. Nor do the individual sisters, or the Sisters in general at Termonbacca, appear ever to have sought medical advice on the general problem or on individual cases.

57 Whilst one witness said that he was made to remain in clothes smelling of urine all day, the bulk of the evidence was that children who had wet the bed were sent to wash. Nevertheless, we accept that the other allegations which we have set out above have been established, and amount to a widespread and systematic behaviour by the Sisters. We consider that the way in which the sisters individually, and as a group, dealt with children who were bed wetters amounted to a serious form of emotional abuse.

58 Another form of emotional abuse alleged was that many sisters frequently made cruel and belittling comments about children in Termonbacca. Remarks such as the dependency of the children on the sisters because they had been placed in the home - "your mother and father don't want you"; and "nobody paying for you to be here" appear to have been widespread. As already pointed out, many of the children placed in the home were illegitimate, and we accept that on one occasion a visiting priest characterised the child concerned "as product of an evil and satanic relationship." Whilst this was made by a priest and not by a sister, we consider that the remark was indicative of a widespread view shared by many of the sisters, as indicated by HIA 157, who was illegitimate himself and said that he was brought up to believe that he was "a mortal sinner".[24] Other derogatory remarks were common, such as "Jew", "tinker", "fishwife" and others. **We**

23 SND 13487
24 Day 20, p. 68 (25 March 2014, closed session).

accept the evidence of many witnesses who described such remarks as diminishing and demeaning them. These remarks have been denied by the individual sisters who gave evidence, but we are satisfied that this was a widespread practice resorted to by many sisters.

59 Another form of emotional abuse alleged was that it was common for sisters to use threats that children would be removed from the home if they did not behave, by being sent to Muckamore Abbey (a psychiatric hospital to which children with learning difficulties were admitted), or a particular social worker would be sent for, the implication being that they would be removed from Termonbacca and sent to another institution. **We are satisfied that such threats were routinely made, and were clearly designed to frighten the children into submission. We accept that this amounted to another form of emotional abuse.**

60 Finally, a pervasive complaint is that there was a lack of individual love and care and affection shown by individual sisters to many of the children in their care. It is true that some had a very close bond with individual sisters, although it is our view that many of these instances are because the sisters concerned showed favouritism towards some children which they denied to others. We have occasion elsewhere in this chapter to refer to Miss Kathleen Forrest's 1953 report, and a number of sisters, such as SR 3, did concede in their evidence that it was impossible to show as much love and affection towards each child as they would have liked because of the large number of children for whom each nun was responsible.[25]

Neglect

61 There were a number of separate allegations that may constitute systemic neglect, and we will deal with these in turn. The first was that children at Termonbacca received inadequate medical attention, in some respects, in relation to specific injuries inflicted by other children or by sisters. In addition, there were more general allegations of poor or inadequate medical attention. A number of applicants alleged that they received no medical treatment in relation to specific injuries. For example, HIA 66 alleged that his nose was broken by another resident, and HIA 94 alleged that he was hit on the head a number of times by sisters, and despite bleeding was not provided with any medical

25 Day 29, p. 22.

treatment. As against this, a significant number of other applicants said that they were provided with medical treatment which involved their being taken to hospital and being given appropriate treatment. One example was HIA 22: he said he was hit on the head with a brick thrown by another boy and taken to hospital where he received eleven stitches. HIA 102 said that a wire lodged in his leg as the result of a sister pulling at him as he was trying to get over a wire fence. He was taken to hospital to have this removed. HIA 125 said that he fell and broke his arm while doing circuits in the gym as a punishment and was then taken to hospital to have his arm set. HIA 151 alleged that he collapsed and had to be admitted to hospital for a week, and he links this collapse to a sister beating him on the head with a towel rail.

62 These are merely a selection of the allegations and evidence by twelve applicants, and we have concluded they indicate that the sisters were prepared to take children to either hospital or to a doctor to receive appropriate medical treatment. Whilst many applicants complained that they were taken to see dentists where they received what they regarded as rough or unsympathetic treatment, their evidence, and some contemporary documents, confirms that regular medical attention was provided. For example, SND 6214 shows that the sisters were sending children to a Dr Devlin, apparently a local general practitioner. A number of documents were produced to us that showed that children did receive medical examinations at the home. In addition, those documents relating to inspections to which we shall refer in greater detail in a later section in this chapter indicate that for a considerable number of years in the 1950s and 1960s inspectors from the Ministry of Home Affairs jointly inspected Termonbacca (and other homes) in the company of a doctor from the Ministry of Health. Whilst not many documents have survived showing what the doctor did, nevertheless there is no reason to assume that a medical inspection would have failed to reveal that the children were ill-fed or neglected in some other way.

63 We have come to the conclusion that it is unlikely that the children were denied necessary medical attention as a general practice. It is, however, possible that on a number of occasions individual sisters were reluctant to take children to hospitals or to general practitioners in relation to what may have been regarded by the sisters at the time as relatively minor injuries which they felt that they should deal with themselves. Therefore, looking at the evidence as a whole, we are not

satisfied that the evidence supports a finding of a systemic failure on the part of the sisters to provide adequate medical attention, either for specific injuries, or as part of the general duty to look after the health of the children in their care.

64 Poor and inadequate food was alleged to have been provided by many of the applicants. However, the evidence in this respect is contradictory. Some applicants said that the food was poor, others felt that it was good or adequate. Particularly in the years immediately following the end of the Second World War, and in the early 1950s, rationing was in force, and it may well have been the case that for many years the food was monotonous and of an institutional type, but that is not neglect. We have referred in the preceding paragraph to medical inspections, and if the children were malnourished we would have expected this to have been identified and remarked upon by medical inspectors and by other visitors to the home, and there is nothing to suggest that this was the case. We feel that there is insufficient evidence to justify a finding that children were neglected because they were inadequately fed.

65 A number of the applicants complained that from time to time they were clothed in hand-me-down clothes. However, whilst this no doubt embarrassed teenagers in particular, it has to be remembered that in the years after the Second World War rationing and poverty meant there was little scope for the Sisters to provide new clothes in the way that would be regarded by a present generation as almost a right. We had the benefit of a number of photographs, which were both obviously posed and unposed, in particular a cine film received from SND 14 of a trip by children to Donegal. All of the photographs show that the children were adequately clothed, and we conclude there is no evidence which would support a finding of a systemic failure on the part of the Sisters to provide adequate clothing for the children at Termonbacca. Some complained that because they were made to wear a Termonbacca uniform to school, or kept in short trousers for longer than other boys, they were singled out as “home boys” at school. Whilst they were embarrassed by this we do not consider that it was abusive to make them wear a uniform.

66 There were some complaints that the bedrooms were very cold, however we consider these were insufficient to be representative or indicative of systemic abuse in the form of failing to provide adequate heat.

67 There was a reference to there being rats in the walls of the temporary structures that were put up in the late 1960s to house the children whilst the new units were being constructed. Given that the home was situated on a farm this may well be correct, but it has to be viewed against the background of the Sisters being in the process of building new accommodation and we do not consider that this can be said to amount to a systemic failing.

68 A common complaint was that gifts of toys, clothes and money given to children were then taken from those children by the Sisters. A related complaint was that items of new clothing sometimes provided to children by their parents immediately before they were placed in the home, or by foster parents with whom they were placed over the summer, were also removed. **We accept that this occurred. Whatever may have been the motive for it, we do not consider that this was a justifiable practice, and we consider that it was a form of neglect.**

Unacceptable practices

69 A considerable number of allegations were made which we group together under the general heading of unacceptable practices. As will become apparent, some of these are capable of amounting to emotional or physical abuse, or other forms of systemic failing, and we propose to deal with these in turn.

70 Many applicants complained that excessive time and effort was spent on cleaning and polishing floors. This seems to be a characteristic of their experiences in the 1950s and 1960s, and many applicants referred to being made to polish the floors at weekends, a task which seems to have occupied them for many hours, and to have been chastised by seniors if they did not do so properly. Sisters who gave evidence denied that an excessive amount of time was spent on cleaning and polishing floors, or on other tidying duties around the home. However, given that many witnesses described the rhyme “River front, river back” we believe that the Sisters must have been aware of this, and that seniors would beat children on occasions if they did not do the work properly. The 1952 Home Office memorandum to which we have referred suggested that children “should be expected to take a moderate share in the daily running of the home, but not at the expense of sleep, meals, education

or reasonable recreation."[26] We consider that it would have been a perfectly reasonable requirement to ask the children to do chores to keep the place clean and tidy, provided always that the requirements were within their physical capabilities and were not excessive in the amount of time or physical effort required of the children. **We accept that in the 1950s and 1960s children were expected to expend an excessive amount of time and energy cleaning and polishing floors. We consider that this went beyond what was acceptable at the time and was a form of abuse.** By the 1970s it appears to have been the case that chores were allocated to children on a rota basis, and were not as physically demanding, something that was much more satisfactory.

71 Several witnesses referred to children being required to help with the sowing and picking of potatoes at the appropriate seasons. Not all complained of this, and this practice has to be viewed against the widespread, if not universal, practice on farms at the time when children were expected to help with potato picking. Indeed so widespread was this practice in Scotland that the Scottish educational curriculum provided for a break in the school year for some two weeks or so in the autumn to allow children to help with potato picking. Therefore, unless the demands were either physically excessive, or involved an inappropriate amount of time, and/or interfered with the children's schoolwork, the requirement to help with potato sowing and picking cannot be described as abusive. We are not persuaded that the demands made were either physically excessive or interfered with the children's schoolwork, and so we do not consider that this amounted to a form of abuse.

72 Girls were admitted to Termonbacca in the late 1960s in an attempt to keep families together. Three female applicants who gave evidence referred to being asked as girls to look after young children in the nursery. Two of the three resented being asked, the third enjoyed doing so. Asking older girls to help with young children can hardly be regarded as abusive provided that it was not something which was demanded of them to an excessive degree; we are not satisfied that it was, and we do not consider that these allegations amount to a form of abuse.

73 Many of the applicants gave evidence that the Sisters took no steps to make them aware that they had siblings in either Termonbacca or in Nazareth House when children from Termonbacca went to primary

26 Paragraph 32.

school at Nazareth House. This is one of the allegations which clearly caused great and lasting distress to many of our witnesses. Sometimes children did learn that they had brothers or sisters in either Termonbacca or Nazareth House, but often acquired this knowledge purely by accident as a result of a casual comment or question by another child. Whilst some of the allegations in this regard were contradictory, as when different members of the same family said on the one hand that they did not know of the existence of siblings when others said that they did, nevertheless we accept the evidence in general of many applicants that they either did not know that they had siblings, or only learned that by accident. For example, HIA 151 described how he was separated from his brothers on arrival and it was some time before he learned that he in fact had two brothers. HIA 68 did not know for several years that he had two brothers in a different home, and HIA 157 only learned that he had a brother in the home when his uncle and aunt and another brother came to visit. HIA 351 described how he had no contact with his two older sisters who were in Nazareth House, nor with an elder brother, HIA 284, who was sent to Australia. SND 48 (who had not originally applied to the Inquiry) gave evidence that he had not been told that he had a sister or a brother.

74 Despite the 1952 Home Office memorandum saying that "The child's link with his own family and relatives should be preserved wherever possible..,"[27] **we accept that there was a widespread and pervasive practice of ignoring and concealing the existence of siblings, whether those siblings were in Termonbacca or Nazareth House. We regard this as a cruel and unjustified practice, and one which was a serious and systemic form of emotional abuse.**

75 Linked to this are the allegations that a great many children were prevented from receiving letters from, and having contact with, their parents. **There is ample evidence that in several instances letters were not passed on to the child concerned, and we regard this as wholly unjustified and consider that it also constituted a form of systemic emotional abuse.** That is not to say that in every case contact with their parents was denied to children who were in Termonbacca. A number of witnesses described how their parents came and spoke to them, but did so in the presence of one or more sisters who would remain in the room. We have no doubt that in many cases both parents and

27 Paragraph 33.

children found the presence of sisters and the overall atmosphere to be an intimidating one, and certainly not one that would have encouraged children to speak freely to their parents. There appears to have been a common practice of visiting falling off, and whilst this may well have been due to difficulties which some parents had in travelling to Derry from remote country areas, or perhaps moving away from the Derry area and losing touch with their children, we have little doubt that the reality was that the intimidating atmosphere was such that visitors were discouraged from coming, even if this was not a deliberate policy but merely a consequence of the atmosphere that pervaded Termonbacca over many decades.

76 Many witnesses referred to what they described as a widespread practice whereby sisters referred to individual children not by name, but by the number placed on their laundry. It is not disputed that the sisters allocated a number to each individual child, and that these numbers were placed on their clothing so that the item could be correctly reunited with the child in question after it had been laundered. This is a sensible approach, but the witnesses who complained of the practice say that the sisters were in the habit of simply referring to the individual child by their number and not by name, and that the witnesses found this a dehumanising experience. It is significant that many of those who gave evidence to us were able to remember their numbers many years later.

77 However, not all the witnesses agreed that they were always known by numbers, for example HIA 144 and HIA 150 both gave evidence to the effect that they were only called by numbers when clothing had to be identified. The sisters who gave evidence asserted that numbers were only used when it was necessary to identify individual items of laundry. HIA 11 asserted that the practice of referring to individuals by number lasted until as late as 1969 or 1970, and he said that it stopped because he told his foster parents about the practice, and they complained to the sisters.[28] The evidence on using numbers is contradictory, and whilst we accept that there may well have been occasions when some sisters referred to children by number, as in the situation described by an applicant, who said that children were called by name and number, because there were four "Johns" (of whom he was one), we are not persuaded that there was a widespread practice of referring to children only by number. We therefore conclude that this did not amount to systemic abuse.

28 Day 11 pp. 121-122.

78 Eight witnesses allege that in various ways they were forcibly made to eat unattractive or unwelcome food. Thus HIA 7 said that she was forced to eat lumpy porridge, and HIA 352 said that she was forced to eat carrots. Five of the seven witnesses who said that they were forced to eat food were female, suggesting that whatever may have occurred before girls were accepted into Termonbacca, this was something that occurred from the late 1960s onwards. Whilst we recognise that this may have happened in some individual instances, it is more likely that many of the children were compelled to eat but were not physically force fed. We feel that there are insufficient instances to justify a finding of systemic abuse in relation to this.

79 A significant complaint by a good many witnesses related to being forced to bath in bathwater which had had Jeyes Fluid added to it as a disinfectant. Information provided to the Inquiry by the makers of Jeyes Fluid indicates that at the beginning of the twentieth century adding Jeyes Fluid to bathwater as a disinfectant was a permitted use by the makers, although this was no longer a suggested use by the 1960s, suggesting that the practice may have changed at some point which cannot now be identified.[29] Nevertheless, the evidence of the majority of the witnesses who referred to the use of Jeyes Fluid was that excessive amounts were added to their bathwater, and as a result caused considerable physical discomfort to them. This practice appears to have been more prevalent in the 1950s. **We consider that Jeyes Fluid was frequently used in excessive quantities; this was unjustified, and was a practice which should have been more tightly supervised and controlled by the Sisters to ensure that the minimum amount necessary was added to the bathwater. We consider that this was a form of physical abuse.**

80 Another complaint relating to bath-time practices was that the bed wetters were made to have a cold bath with Jeyes Fluid in it, as was alleged by HIA 144 and HIA 130. A further complaint was that wooden scrubbing brushes were used with Fairy floor soap to scrub the children concerned. HIA 146, for example, alleged that a deck scrubber was used to wash children. Whilst we accept that there may have been isolated instances of conduct such as this, we do not consider that it was sufficiently widespread or frequent to amount to systemic abuse.

29 SND 16488.

81 A number of witnesses alleged that they were either prevented from, or discouraged from, seeking to make academic progress whilst at school, and they attribute their lack of success in later life to the absence of encouragement to do better whilst they were in Termonbacca. As against this, there is some evidence that a number of children were helped to prepare for the eleven-plus examination, as was the case for SND 76. However, this does not appear to have been a common practice, and we are of the view that where some children were coached or provided with additional support in the form of extra teaching, it may well have been limited to some individuals who were the favourites of the sisters concerned. However, we do not consider that the evidence in relation to this is sufficient to amount to a form of neglect that amounted to abuse.

82 A number of witnesses complained that in various ways they were deprived of toys, presents that took the form of gifts of money, or were not provided with birthday cards or any form of celebration of a birthday. It is convenient to deal with these together. HIA 67 complained that when he was given sixpence by priests for serving at Mass he was required to hand this over to the Sisters. This is an isolated case, but there is a considerable body of evidence that the Sisters provided boys with pocket money from the 1950s onwards, although understandably recollections differ as to the amounts involved. For example, HIA 130 recalled being given a gift of £20 at Christmas, which hardly seems likely in the straitened circumstances in which the Sisters had to exist. Others frequently mentioned receiving two shillings and sixpence, a substantial and reasonable amount of money in the 1950s and early 1960s. Others recall smaller amounts. One allegation that was made was that toys were gathered up and stored, and either not given to children, or only distributed on the basis that all children got something. There was considerable evidence to confirm that until the civil disturbances started in Derry in 1968 children were allowed to go unsupervised down into the city for some hours on Saturdays with their pocket money. This was a reasonable and sensible practice, and one which suggests that the Sisters did all that they could to ensure that children were provided with some form of pocket money and the opportunity to spend it as they wished. So far as the provision of pocket money is concerned, we are not persuaded that the children were neglected in any fashion in this respect.

83 There were complaints that birthdays were not marked in any way in earlier years, and in later years were only marked by the provision of a fried meal. Some witnesses said that their birthdays were marked by the provision of a fry and an angel cake as a special treat, others said that they did not celebrate their birthdays in any way, nor did they receive presents. On balance we are satisfied that the Sisters did make attempts to mark children's birthdays.

84 A matter to which a considerable amount of attention was directed during Module 1 related to the allegation that older boys were allowed to supervise younger boys, and as a result there was widespread bullying and sexual abuse of younger boys by older boys. A number of the sisters who gave evidence denied that older boys were allowed to supervise younger boys in this way, but we have no hesitation in rejecting their evidence in this respect. Many of the witnesses, including a number of those who otherwise gave favourable evidence as to the way they were treated by the Sisters, admitted that older boys did supervise younger boys. **We are satisfied that this was a widespread practice resorted to by the Sisters because their numbers were insufficient to enable them to supervise and control the number of children they had in their care. We are also satisfied that this was a highly undesirable practice and should have been recognised as such at the time by the Congregation,** although we would not go as far as Dr Hilary Harrison who opined that it was never appropriate in terms of good childcare for older boys to supervise younger boys and that such a practice would be a recipe for disaster.[30]

85 **However, we are satisfied that there was a deliberate practice for many years on the part of the Sisters to rely upon the supervision by older boys of younger boys when the sisters were otherwise engaged, perhaps because they were at their personal devotions or because they simply had other duties to attend to and could not be everywhere at once. We repeat that this was a highly undesirable practice, and we are satisfied that it was a major contributory factor to the frequent and widespread bullying and sexual abuse that we are satisfied occurred and to which we have referred earlier.**

86 A significant number of allegations of sexual abuse were made against individuals who had been themselves resident in Termonbacca as

30 Day 38 p. 46.

children, and who returned as adults to visit individual sisters or their friends in Termonbacca. In a number of instances these ex-residents were individuals who were employed by the Sisters on the farm. Those who were employed on the farm, or around Termonbacca itself, clearly were entitled to be on the premises, but the allegation is that in many instances individuals who returned took advantage of their presence to sexually abuse younger children. It is clear there was a willingness on the part of individual sisters to allow ex-residents to return to Termonbacca, apart from a short time at the beginning of the 1970s when the then mother superior stopped ex-residents coming to the home because she felt that they should be made to stand on their own feet. That ex-residents returned was entirely understandable because it was the only home these individuals knew, and in many cases the ex-residents regarded individual sisters as their parents. **However, we are satisfied that a number of ex-residents took advantage of the freedom with which they were allowed to move around the building to sexually abuse younger children. At best there was a naivety on the part of the Sisters in allowing what we consider (despite denials to the contrary), to have been largely unrestricted and unsupervised access by adult males to younger children. This is so obviously an undesirable and dangerous practice that it should never have been permitted. We consider that in this respect there was a systemic failing on the part of the Sisters to prevent sexual abuse of the children in their care.**

87 One of the tragic consequences of the sexual and physical abuse suffered by some of the boys as young children was that when they achieved positions of responsibility as older boys, or returned to the home in whatever capacity in later years, they also engaged in sexual and physical abuse of younger boys, thereby illustrating that those who are abused may become abusers themselves. We believe that this pattern may well account for at least some of the sexual and physical abuse perpetrated by these individuals at Termonbacca.

88 This conveniently leads to consideration of what may be called the aftercare of ex-residents. Until SR 2 started to take an interest in the aftercare of ex-residents in the 1970s, there appears to have been a very maternalistic approach by the sisters to helping the boys in their care find employment when they left the home. A complaint made by several witnesses was that they did not know until the day that they left the home that they were leaving or where they were going, and

that all they were given was a suitcase of clothes and a ticket to their destination. There is a lot of evidence that suggests that the great majority of the boys at Termonbacca were found menial jobs, although for many the Irish Army seems to have been a favourite destination.

89 In the 1970s SR 2 started to make considerable efforts to provide a form of aftercare for the children at Termonbacca. A social worker was employed by the Sisters and his evidence to the Inquiry was that he spent a considerable proportion of his time helping ex-residents. Whilst this was commendable, nevertheless we feel that other provision should have been made for ex-residents by the Sisters, and that the social worker in question should have been required to devote his entire time to looking after the children and improving childcare standards in the home, rather than being told to divert much of his time away from the children.

90 It is clear that the Sisters went to great lengths to arrange for summer placements of children with families. This was a praiseworthy practice in principle, and one that seems to have worked well for several witnesses who spoke in glowing terms of the kindness shown to them by the families to whom they went, sometimes for several years in succession. In many cases they have remained in close contact with members of those families in later life. Nevertheless, we accept the evidence that some were regrettably exposed to sexual and/or physical abuse by the families with whom they were placed. We are concerned that in a number of instances complaints were made by children about the way they had been treated, and their evidence suggests that the Sisters do not appear to have reacted well to any complaints made to them. **We are satisfied that there was a lack of willingness to investigate complaints, or at least there is a complete absence of any evidence that the Sisters to whom these complaints were made investigated any such complaints. We accept that a failure by the Sisters to investigate complaints of sexual or physical abuse made by children against foster parents when those children returned to the care of the Sisters was a form of neglect, and that there was a systemic failing on the part of the Sisters in this respect.**

91 The practice appears to have been that the children were placed with a local family who were recommended as suitable by the local priest to the Sisters, but that no other formal vetting took place. Given the number of children involved, vetting of the more elaborate type that was resorted

to by social services in later years may well have been impossible in the 1950s and 1960s. When the numbers in Termonbacca declined, as they did towards the end of the 1960s, there was less justification for this not being done, and **we consider that the failure by the Sisters to properly vet the families concerned in later years was a form of neglect that amounted to a systemic failing.**

92 At this point it is appropriate to refer to the statutory obligation upon the Sisters under Section 1 of the Children and Young Persons Act (Northern Ireland) 1968. Section 1 placed a statutory obligation upon the Sisters to notify the county welfare authorities of placements with others for periods exceeding one month. It is clear from the evidence that we have received that many of the summer placements were for periods in excess of one month, and therefore the Sisters were obliged to report this to the county welfare authorities. We are satisfied that there was an almost complete disregard by the Sisters of this requirement, and, as we shall explain later, a complete failure on the part of the Ministry inspectors to uncover that this was happening, save in one instance in 1958 where it was discovered by accident as the result of the police apprehending a detainee or internee at a farm in Co Londonderry where two boys from Termonbacca had been placed.[31]

93 A small number of witnesses complained that they were turned away on some occasions after they had left Derry, and when they returned sought admission to Termonbacca because they had nowhere to go. As the ex-residents in question may have been over eighteen when these events occurred they would fall outside our Terms of Reference; we simply record that these allegations were made and make no finding in respect of them.

94 Finally, a number of those who gave evidence complained of an excessive emphasis on religious observance throughout their lives in Termonbacca. Many say that their faith in the institutional church was irretrievably damaged or destroyed by their experiences as children in this home. To many at the present day it may seem neither attractive nor desirable to require young children to attend regular or frequent early morning services, but this was a widespread part of Roman Catholic practice at home and at school, and we do not consider that it can be said to amount to a form of abuse.

31 SND 11651, paragraph 48.

Staffing

95 We have already referred to the small number of sisters who were responsible for directly looking after the children in Termonbacca (as opposed to those working in the kitchen and the laundry). Many of the witnesses who had been children in the home referred to the pressures on individual sisters of having to look after so many children, with one sister being responsible for as many as 40 children or thereabouts at some times. HIA 22, who was in Termonbacca from 1960 until 1975, observed that he did not know how so few sisters could look after 60 boys, and in the 1950s and 1960s the number of children who were looked after by each sister was even greater. That the Sisters were understaffed was conceded by a number of the sisters themselves. In her witness statement SR 2 accepted that "we were under staffed and could not physically watch all of the boys twenty-four hours a day."[32] SR 3 also accepted that the sisters were understaffed when dealing with older boys during her first period in Termonbacca between 1958 and 1960 or 1961.[33]

96 In order to identify the responsibility for this state of affairs, it is necessary to look first of all at the role of the Congregation in these matters. All sisters were allocated from the mother house at Hammersmith by the Mother General of the Order to a particular home. We accept that individual sisters were often asked what form of work they wished to do, but ultimately it appears to us that it was the responsibility of those governing the Congregation to ensure that there were sufficient sisters in Termonbacca who were able to properly look after children in their care, and if there were insufficient sisters available to the Congregation to perform this task, then steps could and should have been taken to try to obtain funding elsewhere in order to employ lay staff to perform tasks which the individual sisters could not perform. It is important to remember that one or two sisters had to look after the needs of a very large number of children, particularly in the 1950s, and that this involved looking after all of the requirements of the children when they were not at school, getting them up in the morning, seeing they were properly clothed and fed and ready for school, and then looking after them when they returned from school, and supervising them in the evenings and at weekends. It is hardly surprising in those circumstances that individual

32 SR 11651, paragraph 48.
33 See Day 29 pp. 9 and 22.

sisters could be overwhelmed by the amount of work which they had to do, and as a result were unable to look after the children without the assistance of older children. Most importantly of all, the **sisters were plainly unable to show adequate love and affection to the individual children in their care because of the number of children with whom they had to deal.**

97 The 1952 Home Office memorandum to which we referred dealt with the question of staffing at paragraph 7. Whilst it is hard to be precise, because of the difficulty in identifying the number of hours which individual sisters had to work, the complement of sisters available to look after all of the needs of the children was plainly inadequate for many years. If one assumes that Termonbacca had as many as 100 boys at its peak, applying the staff ratios suggested in the 1952 Home Office memorandum would have required in the region of three full-time staff for every twenty children, a total of fifteen childcare staff to look after the children, as well as ancillary staff to cover cooking and domestic work. Given that other sisters had other duties to perform, such as being bursar or being in charge of the laundry, there is no doubt that for decades the staffing establishment at Termonbacca was wholly inadequate. As a result, individual sisters had to work very long hours and resorted to assistance from older boys to supervise the young children. **Many of the deficiencies which we have identified can be directly traced to the inadequate number of staff, and the inadequate number of staff played a considerable part in bringing about and perpetuating deficiencies, notably the failure to show sufficient love and affection to individual children.**

98 A further relevant factor is that few, if any, of the sisters working directly with children in Termonbacca had any form of formal childcare training before they started to look after children. It was common for young and untrained women of nineteen or twenty who had come from a sheltered religious background to be given a great deal of work and responsibility because of the number of children they had to look after. Although there was some evidence to suggest that some sisters were sent on Home Office courses in England in the 1950s, and did so with financial assistance from the Ministry of Home Affairs, this fell short of providing adequate professional training. Whilst the Congregation realised that those sisters who had teaching responsibilities needed professional teacher training, substantial childcare training does not appear to have

been regarded as necessary until the 1970s, although it improved thereafter. By the time Termonbacca closed, the levels of qualification were comparable to those in other residential childcare services. An excessive reliance on learning on the job means that poor childcare practices may well be perpetuated. We do not regard this as a systemic failing as this approach was no different to that adopted generally to the training and achievement of residential childcare workers.

99 A further factor in the staffing of Termonbacca which we found to be unsatisfactory was that there was a very high turnover amongst many of the sisters, and it was very much the exception for a sister such as SR 2 to remain in the home for several years. An analysis of the information provided to the Inquiry by the Congregation of the number of sisters who were in Termonbacca reveals that during the 1950s four sisters who worked with boys only stayed for one year, whereas in later years they tended to stay for three-year periods. Only two of the sisters who worked with boys stayed for more than four years, and their average length of stay was 2.2 years. The significance of this is that staffing stability is extremely important to children in care, and so the policy (for so it appears to be) of the Congregation of moving individual sisters so frequently when those sisters were directly in contact with children was wrong. This is because such short periods of time meant that the children were exposed to frequent changes of "parents", and this was poor childcare practice. The work of John Bowlby on bonding and attachment was well recognised from the early 1950s onwards, and the **policy of frequently moving staff amounted to a systemic failing because the Congregation had the ability to keep sisters in post for much longer periods. This practice materially contributed to the unsatisfactory form of childcare which many of the children in Termonbacca experienced because it resulted in the children, who commonly stayed for twelve to fifteen years, being exposed to a succession of carers.**

100 By the late 1960s, the Congregation appreciated the need for a radical change and improvement to the physical facilities at Termonbacca. This took the form of converting the children's wing into three units, each of fifteen children with one sister in charge of each unit. Each unit contained a number of two or three bedded rooms. By then the numbers had fallen to 40 or thereabouts from an average of between 86 to 90 in 1953 to 1958. This reflected a general move away from large

institutions and the increased use of foster care, and as a result the reduced number of children coming into residential care were generally being accommodated in converted or purpose-built accommodation that was much more like a family home. To judge by the report of the Ministry of Home Affairs inspectors on their inspection of Nazareth House in 1960, the Congregation recognised the need to move in this direction by then, because the inspectors recorded that the previous year the mother general recommended dividing the older girls into three groups, and that some work to provide accommodation for this was under way.[34] However, this change in approach does not seem to have moved forward as rapidly as might have been hoped so far as both Termonbacca and Nazareth House were concerned, no doubt in part at least due to the cost involved in converting old buildings to provide the necessary accommodation for the smaller units. As we shall describe, funding such changes was a major problem for Termonbacca later in the decade.

101 There are a number of issues in relation to the funding of Termonbacca which are intimately intertwined with similar issues that arose in relation to Nazareth House and we consider it more convenient to deal with these together. We therefore propose to express our views in relation to the systemic failings which we find in relation to the conduct by the Sisters of Nazareth of Termonbacca before we deal with the equivalent allegations in relation to Nazareth House. We will then consider the question of funding both in the context of funding from other sources available to Termonbacca and to Nazareth House and funding from the relevant local or central government bodies together before expressing our views in relation to systemic failings on behalf of both central and local government authorities.

Findings as to systemic failings by the Sisters of Nazareth at St Joseph's Home, Termonbacca

102 At the conclusion of the public hearings in relation to Module 1, Senior Counsel to the Inquiry posed a number of questions which it was suggested the Inquiry might wish to make in relation to both Termonbacca and Nazareth House, and at this point we propose to answer ten of those questions in relation to Termonbacca only. The

34 SND 9211.

remaining questions are more appropriately dealt with in the context of the findings which we express later in this report in relation to funding.

103 In the light of the conclusions which we have expressed in the earlier part of this chapter the Inquiry makes the following findings in respect of the Sisters of Nazareth and the children in their care at Termonbacca.

(1) We are satisfied that there was abuse in the form of improper sexual or physical behaviour by individual sisters towards children in their care.

(2) We are satisfied that there was abuse in the form of improper sexual or physical behaviour by other adults, employees, visitors and priests towards children in the care of the Sisters of Nazareth.

(3) We are satisfied that there was abuse in the form of improper sexual or physical behaviour by older children towards children in the care of the Sisters of Nazareth.

(4) We are satisfied that there was emotional abuse in the form of improper behaviour by individual sisters towards children in their care which undermined the self-esteem and emotional well-being of the children.

(5) We are satisfied that there was emotional abuse in the form of improper behaviour by other adults, namely employees, visitors and priests towards children in their care, behaviour which undermined the self-esteem and emotional well-being of the children.

(6) Although there is evidence of poor childcare in some respects, we consider this did not amount to systemic neglect.

(7) We are satisfied that individual sisters and those in positions of authority within the Congregation at Termonbacca were aware of the matters dealt with at 1,2,3,4, and 5 above.

(8) We are satisfied that no, or alternatively inadequate, steps were taken by the Sisters of Nazareth to prevent such abuse.

(9) We are satisfied that individual sisters, and those sisters in positions of authority within the Congregation, did not take proper steps to report such abuse to the relevant civil authorities, namely social services and the police.

Part Two:

Nazareth House, Bishop Street

104 Although it seems that 2,347 children were accommodated in Bishop Street during its existence of approximately a century, only eleven witnesses came forward to the Inquiry to complain about the way they were treated. One of these did not give evidence in person due to her ill health in Australia, and another made a statement to the Inquiry but did not attend to give evidence when requested. As she did not provide a satisfactory explanation as to why she did not attend, the Inquiry decided to disregard her evidence. This leaves nine witnesses who came forward and gave critical evidence in person in relation to their time at Nazareth House. In addition we heard from two other ex-residents who gave evidence after being put forward as witnesses by the Sisters of Nazareth, and one of those criticized the pre-1950 period. We heard also from four sisters, three social workers and three others. The allegations made to us, and the conclusions which we have reached, have therefore to be viewed against a much lower number of allegations in relation to Nazareth House when compared to those in respect of Termonbacca.

Improper sexual behaviour by an adult or another child towards a child

105 We received a single allegation of sexual abuse committed by a sister in Nazareth House. HIA 105 alleged that when she was four to five years of age, and still in the nursery, a sister whose name she could not remember brought her into the sister's own room within the nursery, told her to lie on the floor, pulled up her habit, straddled her and made HIA 105 lick her vagina. Many years later she says that she contacted SR 18 and told her about this incident because she had remained in contact with SR 18 over the years and considered that she was on good terms with her. When SR 18 gave evidence to the Inquiry she accepted that HIA 105 had contacted her, and that the witness did tell her about sexual abuse to which she had been subjected by a sister. HIA 105 further alleged that SR 18 rang her back shortly after the initial telephone conversation and identified a particular sister as the possible perpetrator of the alleged offence. However SR 18 was subsequently interviewed by the police in January 2012 and made a statement to

them about a number of matters, including this conversation. In the account SR 18 gave to the police[35] it is clear that she is denying that there was such a conversation, and that account does not sit easily with her acceptance in her evidence to the Inquiry that there was such a conversation. SR 18 denied that she identified the possible perpetrator in the manner alleged by HIA 105. We found HIA 105 to be articulate and objective in her account of other matters, and we accept that she was generally an impressive witness.

106 Having considered all of the evidence by both witnesses in relation to this matter we prefer the evidence of HIA 105 on this allegation. Accordingly, we are satisfied that a sister who cannot be accurately identified did commit this isolated act of sexual abuse towards this witness. This leads us to consider whether or not this amounted to a systemic failing. We do not consider that it can be so regarded, because whilst it was a grave breach of trust on the part of the sister concerned to behave in this fashion, there is no evidence that would justify us in concluding that the Congregation could have prevented this. However, the fact remains that SR 18 accepts that such an allegation was made, the matter has been placed in the hands of the police and is a matter for them. So far as the Congregation is concerned, neither SR 18 nor the Congregation reported this to the police at the time it first came to their attention in and around 2003 or 2004 as HIA 105 alleges. **We regard this failure to report as a systemic failing.**

107 HIA 49 alleged that she was persistently abused by two separate priests. One has been given the designation SND 61. She alleges that on a constant basis between the ages of eight to twelve she was sexually abused in a number of different ways by this priest when she was taken to confession conducted by him. She says that he took her into the confession box and put his hand down the front of her pants when she was eight years old. On later occasions she alleges that he took her into the sacristy behind the altar, locked the door and then performed a number of sexual acts. She alleges that he masturbated in front of her, made her perform oral sex on him, frequently penetrated her vagina digitally and had anal sex with her. In addition she alleges that he was very rough with her and pulled her hair. When he had finished abusing her she says that she would return to her group and sometimes he gave her a mint. She alleges that one of the sisters must have known what

35 See SND 15154.

was going on, because she always placed the witness at the end of the queue and put her hand into the priest's hand. We accept that such events occurred.

108 HIA 49 makes a separate set of allegations against another priest whom she identified as SND 106. She alleges that this priest bounced her up and down on his lap in the playground of Nazareth House when he had an erection. We have carefully considered the nature of her identification of the priest in question, and have concluded that she was inaccurate in her identification of SND 106 as this priest. However, SND 407 (who is now deceased) was a priest with the same name as SND 106 and, unlike SND 106, did serve as a chaplain at Nazareth House for a number of years. In addition, the physical description of the priest in question as "short and stocky" is compatible with the appearance of SND 407. We have concluded that as the two priests had the same name, HIA 49 is mistaken in her belief that she was assaulted by SND 106, but we accept she was assaulted by SND 407.

109 In the light of the accounts given of the abuse to which she was subjected by these two priests, we accept that HIA 49 did suffer sexual abuse. So far as SND 407 is concerned, we consider that this did not amount to systemic abuse on the part of the Sisters, because if his behaviour had been observed it would have appeared to be innocuous behaviour that would not have raised concern, because at that time no one would have believed that a priest would have behaved in that fashion. However so far as SND 61 is concerned, that the priest had the child in question in the sacristy with the door locked for a significant period of time should not have gone unnoticed. **This, together with the fact that confessions would have been heard in the confessional and not in the sacristy, leads us to conclude that there was a systemic failing on the part of the Sisters to appreciate that some form of improper conduct may have been perpetrated when the priest was repeatedly spending a lengthy period of time locked in the sacristy with a young child when the child was supposed to be making a confession. Such a situation could not account for such a prolonged absence of the child from view.**

110 HIA 233 alleged that a priest in Nazareth House who came to say Mass at the chapel every Sunday, and who is now dead, put his hand on her leg and rubbed her thigh. This happened on more than one occasion. Whilst a less serious form of sexual abuse, if such conduct occurred it was plainly a form of abuse which was perpetrated in circumstances

where it could have been observed and should have been prevented. However, the amount of detail given by the witness does not enable us to conclude whether or not her account is reliable in this respect.

111 Two witnesses described how they were sexually interfered with during periods of time when they had been placed with families in the country during the summer months. HIA 367 said that this happened on two separate farms. On one occasion a workman on the first farm touched her private parts and was observed by the farmer. She alleges that on other occasions the farmer called her into a private part of the farm where they would not be seen and also touched her private parts. On one occasion when she was sharing a bed with another girl the farmer came into bed between them but his wife discovered him and told him to get out. The witness said that she was taken back to Nazareth House, where she tried to tell SR 9, who was the sister in charge of her group, what had happened. She alleges that SR 9 would not listen to her and said that she did not want to know.

112 The witness also alleged that on another occasion she was sent to a different family when she was aged about twelve and spent two months there over two summers. She alleges that the father of the house sexually propositioned her and offered her money, but he was disturbed when someone returned to the house. She said that in the early hours of the following morning she ran away and went to the farm of the first family to which reference has been made. She was picked up by the wife who asked her what she was doing and in due course HIA 367 wrote to SR 9 and asked her could she return to Nazareth House. She was put on the bus and returned. It does not appear that she disclosed this episode to SR 9.

113 Broadly similar allegations were made by HIA 169, who described how she was sent to different families on a number of occasions. She alleges that on two of these visits she was sexually interfered with. The first occasion was when she was either five or seven years old. She says that she was propositioned by the son of the family who offered her money and she remembers lying on the haystack on her back with him on top of her and experiencing a severe pain in her vagina with something inside her, which she assumed was his penis, and she believes that he raped her. She went out of the field and was found by the mother of the house and the next day she was sent back to Nazareth House. She did not disclose what had happened.

114 The other occasion that she describes occurred when she was eleven or twelve and she describes how the son of that family had intercourse with her, both vaginal and anal. A sister from Nazareth House came to collect her the next day, and on her return SR 9 beat her, calling her horrible, filthy names and telling her that what had happened was her fault.

115 We accept the accounts by HIA 367 and HIA 169. The Sisters may not have been able to properly vet the families concerned at the time, given the very large number of children involved, nevertheless the children were still in the care of the Sisters, despite being on a placement, and the Sisters should have realised that children in care were more liable to sexual exploitation, and taken the allegations more seriously. There was a clear failure to take proper action when the allegations were disclosed to the Sisters by these witnesses. There is nothing to suggest that these serious matters were reported by the Sisters to either social services or to the police, a course which should have been taken and which we are satisfied was not taken. We are satisfied that there was a failure on each occasion to pay proper attention to the children's complaints and then to pass them to the social services and/or police. **The failure of the Sisters to do that was a clear systemic failing in their duty to properly consider, and then report the allegations to the proper authorities.**

116 An isolated episode of sexual abuse alleged by HIA 233 was that when she was a child of seven in 1966 and in Nazareth House, she was sexually interfered with by her half brother, SND 283. She says that he digitally penetrated her every other night for weeks when he came to her room from a separate room where he lived. She alleged that this was observed on the first occasion by another girl with whom she shared the room. She also alleged that she later told her mother what SND 283 had been doing to her in front of one of the sisters whereupon her mother slapped her face. She also alleged that she had reported this to a social worker.

117 It is clear from the witness's evidence that if these matters were reported to her social worker as she says then the matter was placed in the hands of the proper authorities. However, there is no evidence to support her assertion that it was reported to her social worker,[36] and in

36 Day 16, p. 87.

these circumstances we do not reach any conclusion as to whether or not this episode occurred.

118 HIA 242 (who was unable to give oral evidence due to ill health) made a statement in which she alleged that during her time at Nazareth House, when the children were playing in the playground at the back of the home, some of the elderly men who lived in the old people's section of the complex "would walk past us and expose themselves to us. We never reported this to the nuns." Whilst we accept that repeated acts of indecent exposure of the type alleged could amount to a form of sexual abuse, and could amount to a systemic failing on the part of the Sisters if they were aware of it and did not take steps to prevent it, the statement suggests that they may not have been aware of it because it was never reported. In any event, this is an isolated complaint, and even if these events occurred, in the absence of any report we are not satisfied that it could amount to a systemic failing on the part of the Sisters.

119 There was only one allegation of sexual abuse of an applicant, when HIA 49 alleged that on one occasion she was made to touch another girl's vagina. We do not have to determine whether some such incident occurred, because if it did it was plainly an isolated incident which could not have been prevented and therefore would not amount to a systemic failing on the part of the Sisters.

Physical violence

120 Seven witnesses altogether, six of whom applied to the Inquiry and one of whom (SND 463) came forward to give evidence in support of the Sisters, alleged that significant violence was inflicted by a number of named sisters on many occasions, although SND 463 alleged that this type of conduct was only prevalent until 1950 or thereabouts. We accept that, as in Termonbacca, a number of sisters repeatedly and frequently resorted to significant violence against a number of the children in their care. A number of these allegations were directed at SR 9. HIA 169 alleges that on two occasions SR 9 struck her with such severity as to break her nose. On another occasion it is alleged that SR 9 struck her a severe blow with a brick. A fourth allegation is that on a separate occasion SR 9 struck HIA 169 on the side of the head causing the child's head to bang against a protruding ledge on a wall. So far as the first three incidents are concerned, we have taken into account the evidence

of a number of witnesses such as SND 463 who spoke extremely highly of SR 9, and who believed that she would not have been capable of such behaviour. So far as the fourth occasion is concerned (the ledge incident) the account by HIA 169 was to a limited degree corroborated by the evidence of SR 18, another sister who was present at the time and who gave oral evidence to the Inquiry. In her witness statement SR 18 described how she had reason to be displeased with the behaviour of HIA 169 and so she took her to SR 9. She went on to describe how SR 9 "lifted her hand to give HIA 169 a clip on the ear but HIA 169 quickly moved her head to the side to avoid SR 9's hand, but banged the side of her head against a cabinet nearby. I did not see what happened next, because SR 9 asked me to go upstairs. I believe HIA 169 has a scar on the side of her head as a result of this incident. I was shocked as I never previously witnessed anything like this incident."[37]

121 In her oral evidence SR 18 confirmed that she witnessed this incident,[38] and we regard the evidence of SR 18 as providing substantial corroboration of the allegation by HIA 169 against SR 9 in respect of these incidents, and we accept that she was struck a severe blow with a brick with such violence by SR 9 that she banged her head against the side of the wall. We regard this as unjustified and excessive physical chastisement.

122 Looking at all of the evidence of HIA 169 and of the remaining witnesses who have alleged that violence was inflicted upon them by individual named or unnamed sisters, we are satisfied that a number of sisters frequently resorted to severe chastisement of an excessive and wholly unjustified nature in relation to a significant number of girls.

123 Three witnesses, HIA 105, HIA 394 and HIA 49, allege that they were beaten by senior girls. For example, HIA 105 said that a particular girl who was the only one she could remember "was left do a lot of things on her own in her own way and was allowed to."[39] HIA 394 made similar allegations, saying that the older girls were in charge and were quite brutal: "they seemed to be allowed to do anything, and I did once report their behaviour to a nun, because I was being so badly - I was being very badly beaten because I was trying to get up into the nursery and I was being beaten down." She repeated that she did complain to a sister

37 SND 15834.
38 Day 29, p. 155.
39 Day 8 p. 14.

and "was told to go away and stop telling tales".[40] HIA 49 alleged that when she was in the bath her back was scrubbed with a brush, which appears to have been a floor brush of some sort, by senior girls.

124 Although there are only a small number of such complaints, given that there were a small number of sisters available to look after a large number of children, a problem to which we have already referred and which was compounded by the teaching duties of the same sisters, we accept that at times and to a significant degree there was a practice of giving too much unbridled authority to some senior girls, who then abused the power that they were given and assaulted younger girls. **We consider that it was an unacceptable practice and one which allowed abuse to be perpetrated and constituted a systemic failing on the part of the Sisters for the reasons we have already set out in respect of the same practice at Termonbacca.**

125 One witness (HIA 127) alleged that on one occasion he became involved in an altercation with one of the houseparents in Nazareth House, SND 43. She was married and during the course of the altercation HIA 127 alleges that he struck SND 43, and he further alleges that SND 44, who was SND 43's husband, later came in to the home and assaulted him because he, HIA 127, had assaulted SND 43. SND 43 gave evidence and denied that her husband had come in and acted in this way, but we did not find her evidence persuasive on this matter and we are satisfied that there was such an incident. In his response to the Inquiry Warning Letter SND 44 denied that such an incident took place. HIA 127 was not the only witness to allege that this individual had ready access to the home because similar evidence was given by HIA 233. We accept that he did have ready access to the home, and **we regard this as indicative of a systemic failing on the part of the Sisters to exercise proper control over who was allowed into Nazareth House, and where they were allowed go**. The fact that the individual concerned was the spouse of a staff member should not have permitted ready access by him to any part of the home**.**

Unacceptable practices

126 A number of witnesses described the manner in which children who wet their beds were treated. Although only four witnesses referred to

40 Day 8 p. 59.

this matter, the allegations cover several decades. The earliest in chronological terms was the account given by SND 463 in relation to the pre-1950 period. She described how bed wetters were woken and then made to have a cold bath. HIA 242 (who did not give oral evidence) described a similar practice during her time at Nazareth House between 1948 and 1964. She also described how bed wetters were woken, but went on to say that they were then made to put the wet sheets on their heads. The two remaining witnesses were HIA 105 and HIA 169, who were in Nazareth House between 1962 and 1975 and 1961 and 1976 respectively. HIA 105 described how she saw bed wetters being singled out by being made to stand for breakfast and only being given half a cup of tea at nighttime. Bed wetters were also made to wash their own sheets. HIA 169, who was herself someone who had a problem with bed wetting throughout her time in care, recalled how bed wetters were humiliated by being made to put their underwear on their heads and stand at the breakfast table so that everyone could see. HIA 105 also referred to girls who wet their pants having to wear their pants on their head and parade up and down the corridor where the dormitories were.

127 We accept that the attitude towards girls who wet their beds, or their underwear, in Nazareth House was evidence of a backward and unpleasant attitude towards them, just as there was at Termonbacca. We have already referred to the wise guidance given by the Home Office memorandum in relation to bed wetting at paragraph 54 above. We are satisfied that some sisters dealt with children who were bed wetters in a manner which amounted to a serious form of emotional abuse.

128 Several witnesses referred to several sisters making humiliating, cruel and disparaging remarks in a way which made the witnesses feel unwanted or worthless. HIA 113, who transferred to Nazareth House when Termonbacca closed (and who had no other complaints about her time at Nazareth House) recalled how she was about to go to a nearby shop with other children when a sister pinned her by the arms and said "Are you going whoring?"[41] Some of these remarks were about their background, some about stains on their underclothing and others about the changes to their body with puberty. For example, HIA 105 was constantly told that she was lucky to be there and she said "they still made you feel very unwanted, worthless, no sense of belonging" and

41 Day 16 p. 31.

that they "made you feel very worthless".[42] HIA 233 alleged that one sister called her and her sisters, "bastards" whilst HIA 242 recalled how she was always being told that she was no good and how SR 9 constantly made fun of the changes in their bodies during puberty. HIA 179 asserted that the sisters used "humiliation, shame and guilt to keep us submissive".[43] Although these complaints are few in number, they chime with similar evidence from Termonbacca; we regard them as credible and consider that they amounted to a form of emotional abuse.

129 A related complaint was that the sisters were markedly unsympathetic to girls facing the problem of the onset of menstruation. This allegation was made by HIA 242, and a number of other witnesses described how they received little if any instruction in the use of sanitary towels, and how sanitary towels were only provided on a limited basis. Although we do not consider that this was sufficiently widespread to justify a finding that there was a systemic failing on the part of the Sisters to treat children who were menstruating in an abusive fashion, nevertheless it shows a marked lack of appreciation of the emotional needs of girls entering into a stage in their development which can be upsetting and embarrassing for the girls concerned if not treated sympathetically.

130 Two witnesses, HIA 105 and HIA 179, alleged that when they gagged upon, and then regurgitated, food which they found inedible they were made to eat their own vomit. In the case of HIA 179 this occurred on one day and she said that the person who made her eat was a civilian worker. HIA 233 and HIA 394 said they were forcibly fed by several sisters and by a civilian worker. However, we are not persuaded that a general practice existed of force feeding children.

131 Only HIA 242 made specific allegations about the quality of the food, saying that she found it poor and inadequate. Given that only one of the small number of witnesses who came forward made such a complaint we accept that the food, whilst no doubt institutional, particularly in early years, was adequate and nutritious.

132 HIA 105 and HIA 367 said that birthdays were not celebrated. They also gave contradictory accounts about Christmas. HIA 105, who was in Nazareth House between 1962 and 1976, said that she did receive a single present at Christmas, such as a selection box and

42 Day 8 p. 39.
43 Day 8 p. 105.

nightgown, and that Christmas was lovely, whereas HIA 367, who was a contemporary in that she was there from 1958 to 1970, said that although they were given clothes and shoes at Christmas, they received no toys. We consider that there is insufficient evidence relating to the provision of toys, clothes and the marking of Christmas and birthdays to amount to evidence of a systemic failing on the part of the Sisters to provide for the children in these respects.

133 So far as pocket money is concerned, HIA 367 said that they only received pocket money when children were going on trips to somewhere like Butlins, and HIA 105 said they received a small amount "once in a blue moon then it stopped." However HIA 169, who was a contemporary of both of these witnesses since she was at Nazareth House between 1960 and 1974, said that the girls did receive pocket money unless they were punished, in which case it was withheld. In relation to a matter such as this, the fact that one child says that they did receive pocket money is of greater significance than those who say they received it only on a limited basis, and we are therefore satisfied that pocket money was provided to the children and there was no failing on the part of the Sisters in this respect.

134 HIA 367, HIA 105 and HIA 169 all made complaints in relation to the provision of bathwater. For example, HIA 367 said that there were only two baths for over a hundred girls and that the water was never changed. The account given by HIA 105 was slightly different in that she said that ten to fifteen people had to use the same water, whereas HIA 169 said that all girls used the same bathwater. SND 463, to whom we have referred earlier as coming to give supportive evidence on behalf of the Sisters, accepted that the children were made to bath three at a time, but that there was plenty of hot water. She also referred to small amounts of Jeyes Fluid being added to the bathwater. The fact that more than one child used the bathwater is not surprising in a large institution, indeed many families would have adopted the same practice. Nonetheless the evidence suggests that the changes of bath water were not sufficiently frequent. While this did not represent abuse in the sense of neglect, it did represent poor childcare.

135 Several witnesses alleged that the children were made to perform heavy and repetitive household chores to an excessive extent, such as HIA 367 who referred to being made to spend a long time washing clothes on one occasion when the washing machine broke down. HIA 242 (who

did not give oral evidence), and who was in Nazareth House between 1948 and 1964, also alleged that a great deal of time was spent by the children cleaning and scrubbing and waxing floors. HIA 105 also referred to the amount of time spent helping others clean corridors and classrooms. However, SND 60 (who was in Nazareth House from 1962 to 1976), described how the children were made to wax and polish floors, saying that it was not a hard job, they always had a laugh and enjoyed doing it because three girls would stand together in a line and "we used to sing a song '0,1,2,3, Mary at the cottage door. 5,6,7,8, eating cherries off a plate'." The evidence is therefore contradictory as to the practice of cleaning floors in the 1950s and 1960s. We are not persuaded that excessive or unreasonable demands were made of the children in that respect.

136 An additional allegation made by HIA 105 was that when she was five she was made to clean toilets every Saturday. **HIA 49 and HIA 179 also alleged that they had to clean the toilets. We accept that these episodes occurred, and in view of the ages of the children, and the nature of the tasks, we consider that this amounted to a form of abuse.**

Staffing

137 Whilst the questions of staffing and funding are closely intertwined, it is appropriate to look at the number of sisters who were available to look after the children in Nazareth House. It is clear that for many years the number of sisters was extremely limited. HIA 105 and HIA 394 were both in Nazareth House in the early 1960s: HIA 394 from 1961 to 1964; and HIA 105 from 1962 until 1976. HIA 394 commented "I wondered if it was just overwhelming for them. I just wondered if they knew how to cope themselves." As already explained, the practice until well into the 1970s was that some sisters were allocated to spend the day collecting in the community, whilst others were trained as teachers and were expected to teach full-time in the primary school run by the Sisters on the same site, and, as we have heard, for many years the boys from Termonbacca attended this school with the girls from Nazareth House. The teaching sisters were also expected to look after the children in the morning and the evening before and after school. SR 52 who was in Nazareth House between 1967 and 1975 (apart from one year when she was in Belfast undergoing a course on

nursery education) described how one of the three teaching sisters would get the children up in the morning, see that they were dressed and made their beds. A second teaching sister then supervised and served breakfast, and after breakfast the third teaching nun prepared the children to leave for the various schools. After her day's work as a teacher, SR 2 returned to the home and it was her responsibility to take the boys from Termonbacca to the bus that they would get back to Termonbacca. She then went back to Nazareth House, and organised and supervised games and other activities until the children had their tea at five o'clock. Another sister then usually took over at teatime, followed by another sister who took over at about 6.30pm. After that the sisters went for prayer, and on their return put the children to bed.[44] Any other teaching sister who was free would help out, as would the collecting sisters. SR 147 was a collecting sister, and in a letter which she wrote on 23 July 2013[45] she described how when she arrived in Derry in 1968 or 1969 "I was expected to go and help make beds in the two dormitories, also to clean the bathrooms, and sweep and mop the dormitories before I went out."

138 This pattern continued for many years; SR 52 pointing out that between 1967 and 1975 when she was in Nazareth House there were no civilian staff employed to help.[46] The evidence from SR 18 was the same. She was in Nazareth House between 1972 and 1973 and returned to Derry from Belfast in 1977. When she returned in 1977 she found that there were still no civilian staff, and as a result she had to arrange for a lady to come in to help between 4pm and 9pm.[47] Overworked individuals may well have felt it necessary to resort to violence or abusive language in order to try and maintain discipline over a large number of children.

139 Quite apart from the pressures created by the inadequate numbers, the teaching sisters had no childcare training as such, although SR 18 claimed they did have a significant element of childcare development training as part of their teacher training course.[48] However, as SR 52 conceded, she was very ill-prepared for the dual role she was expected to undertake when she arrived in Nazareth House as a trained teacher in her early twenties. As we shall see when we consider the question of

44 Day 29 pp.75 to 77.
45 SND 17181.
46 Day 29 p. 77.
47 Day 29 p. 130.
48 Day 29 p. 131.

funding, it was not until the vigorous efforts of SR 2 in the late 1970s and early 1980s led to a substantial recruitment of lay staff, so that by the time Nazareth House closed it was fully staffed with trained staff. Given that in the earlier years few, and inadequately trained, sisters were responsible for looking after a large number of children, it is hardly surprising that the routine in the house was a regimented one, a state of affairs that remained until the smaller units were created in the mid-1970s. As we have already observed in connection with Termonbacca, it was the responsibility of the Congregation either to ensure that there were sufficient and adequately trained sisters available to properly look after the children, or to seek to obtain the necessary funding in order to recruit civilian employees to perform the tasks which the sisters could not cope with. Whatever may have been the responsibility of public authorities to provide funding, the Congregation itself must bear a substantial share of the responsibility for this state of affairs.

Findings as to systemic failings by the Sisters of Nazareth at Nazareth House, Bishop Street

140 At this point it is appropriate to consider a number of the questions that were posed to the Inquiry and which we have already answered in relation to Termonbacca. We propose to do so in relation to Nazareth House at this point before we turn to other matters, principally funding. In the light of our conclusions set out above we make the following findings in relation to the Sisters of Nazareth at Nazareth House.

(1) We are satisfied that there was abuse in the form of improper physical behaviour by individual sisters towards children in their care.

(2) We are satisfied that there was abuse in the form of improper sexual behaviour by a visitor and by priests towards children in the care of the Sisters.

(3) We are satisfied that there was abuse in the form of improper physical behaviour by older children towards children in the care of the Sisters.

(4) We are satisfied that there was emotional abuse in the form of improper behaviour by individual sisters towards children which undermined the self-esteem and emotional well-being of the children.

(5) We are satisfied that the Sisters of Nazareth were aware of the matters alleged at 1, 2, 3 and 4 above, and took no steps to prevent such abuse.

(6) We are satisfied that the Sisters of Nazareth did not take proper steps to report such abuse to the relevant civil authorities, namely social services and the police.

We will deal with the remaining questions relating to premises, staffing and funding after we have considered the evidence in relation to these matters.

Sexual abuse and the responsibility of the Western Health & Social Services Board

141 At this point we turn to consider a specific allegation made against a residential social worker employed by the Western Health & Social Services Board (WHSSB) in Nazareth House, and whether there were any failings on the part of the WHSSB in relation to these events. HIA 127 spent a number of short periods in Termonbacca as a very young child before being placed in foster care with his five siblings, three of whom were applicants to the Inquiry, and the fourth of whom gave evidence. All six siblings remained with their foster parents until allegations of sexual misconduct made against the foster parents led to four of the children being placed in Harberton House. HIA 127 remained there for some months until he was placed in Nazareth House with two of his siblings in April 1986. By then HIA 127 was aged ten, and he remained in Nazareth House for just over four years until he was discharged in 1990 aged fourteen. During the time he was in Nazareth House he was in the unit in the charge of SR 21.

142 The allegations made by HIA 127 fall into two distinct categories. He makes a number of allegations about the way he was treated by the staff, both lay and religious, during his time in Nazareth House. He says that he was shouted at and punished every day for various misdemeanours. He suffered from psoriasis, and the contemporary records show that he was prescribed Polytar to be applied to the skin to treat this condition. He alleges that despite instructions to the home by his doctor that it was inappropriate that he should be bathed every night because this would remove the positive effect of the natural oils from his body, he was either bathed or showered every day, sometimes being forced into the shower by the staff. Another allegation he makes is that when

he was aged about ten he had to undergo an operation on one of his testicles, and when a nurse came to the home to check the condition of the wound after the operation the nurse inspected him lying on a sofa in front of everyone, something which made him feel humiliated and degraded. It is appropriate to record at this point that, without going into unnecessary detail, HIA 127 has had an extremely disturbed and dysfunctional life, and it was said very strongly on behalf of SND 38 in the closing submissions, notably those set out at SND 18558, that this affects his reliability.

143 These allegations are made against SND 38, who was employed as a residential worker at Nazareth House and was appointed as the key worker for HIA 127. The allegations are that over a substantial period of time SND 38 groomed HIA 127 in various ways. HIA 127 acknowledges that SND 38 treated him kindly and sensitively at the beginning of their relationship, but also refers to him being given frequent treats by SND 38, such as being taken to ten pin bowling and being bought computer games. He goes on to allege that SND 38 subsequently subjected him to episodes of sexual abuse on a regular basis in a number of different locations. These episodes occurred in Nazareth House, both in HIA 127's bedroom and in a bathroom there; the home of SND 38's girlfriend; in a mobile home or caravan in Portstewart in the summer of 1990, and in SND 38's mother's home during a Christmas visit in 1990.

144 HIA 127 alleges that the sexual abuse took the form of SND 38 touching the penis of HIA 127, masturbating HIA 127 and himself, and subjecting HIA 127 to oral sex. After his period of time in Nazareth House HIA 127 was placed in foster care, and he alleges that during his period of foster care SND 38 regularly visited him at his foster parents' home where he took advantage of being allowed to be alone with HIA 127 to subject him to further episodes of masturbation and oral sex.

145 It is clear from both the evidence of HIA 127, and from the contemporary records kept by the WHSSB, that when HIA 127 left foster care he continued to have a very disturbed childhood, being eventually returned to Nazareth House for several months before he was placed in St. Patrick's Training School in Belfast. After he was discharged from St. Patrick's on attaining the age of sixteen he lived in a number of locations and in 1996 he made a complaint that he had been subjected to sexual abuse by SND 38. This resulted in a police investigation in 1996 during which he made a lengthy witness statement.

146 SND 38 also gave evidence to the Inquiry by way of a written statement and oral evidence. He denied all of the allegations, and pointed to a number of significant inconsistencies in the accounts which HIA 127 has given of these events. In particular, it was pointed out on his behalf that HIA 127 changed the date of the Portstewart episode from 1990 to 1989 as it had been pointed out that it could not have happened in 1990 as originally alleged, because by that time he had been placed with his foster parents. In his police statement made on 12 August 1996 HIA 127 alleged that SND 38 drove him around in a red Lada car, but SND 17174 shows that SND 38 did not obtain such a car until July 1990, which is asserted to be a further significant contradiction in the account given by HIA 127.

147 A significant aspect of the allegations, and the surrounding circumstances, relates to the circumstances in which SND 38 came to perform the role of both key worker and "befriender". It is clear that the suggestion that HIA 127 could benefit from someone acting as a "befriender" came from SND 38 himself (although it was signed off by the sister in charge of the unit, SR 21). The reason recorded at the time for this was that HIA 127 "enjoys and thrives on the individual attention that is not always available in a residential setting."[49]

148 We accept that there are numerous contemporary references in the WHSSB records showing that the relationship between SND 38 and HIA 127 was seen as positive at the time. However, the appointment of a residential worker who was already the key worker of the child concerned in the additional capacity of a "befriender" was a highly unusual one. It certainly provided an enhanced opportunity for SND 38 to be alone with HIA 127 on many occasions, and to develop a very close relationship with him, something that would facilitate acts of sexual abuse of the type alleged by HIA 127 if such episodes occurred.

149 We have carefully considered the evidence in relation to the allegations, and there are a number of matters which appear to us to be of considerable importance when considering the clash between the evidence of HIA 127 and SND 38. We accept the evidence of SND 500 that, contrary to the suggestion made by SR 21 in a police statement, it was not the policy of the WHSSB at the time to try to have children visit the homes of key workers.[50] That SND 38 took HIA 127 to his then

49 SND 5228.
50 Day 28, pp. 68-69.

girlfriend's home on a number of occasions is a matter of considerable significance. In addition, when one considers that the suggestion that a "befriender" be appointed came from SND 38,[51] that has added significance in the context of the setting in which it is alleged that these acts of sexual abuse occurred.

150 We also attach significance to the number and regularity of the visits which SND 38 paid to the home of the foster parents with whom HIA 127 was placed after he left Nazareth House. Whilst SND 500 referred to these as being not normal practice but something about which SND 38's superiors or other social workers would not have been unhappy if they did occur, the frequency of such visits provided a further opportunity for sexual abuse to occur it if it did occur.

151 We regard as particularly significant that the foster parents themselves told the Board that they were concerned about the nature and frequency of the visits which SND 38 continued to pay to HIA 127. It was minuted on 19 October 1990[52] that:

> "…they feel that it is too intensive, that they were not fully consulted about setting it up, and that it represents something of an intrusion into the routines of their home. It was established in the course of the review that this form of support was not planned when HIA 127 was discharged from residential care;".

The minutes go onto record that a social worker was to discuss this with SND 38 with a view to "reducing the extent of his involvement". There is no reference in social work records to this discussion having taken place with SND 38, and in his evidence to the Inquiry SND 38 stated that he had no memory of having any such discussion with HIA 127's social worker.

152 On balance we have come to the conclusion that HIA 127 was sexually abused by SND 38 on a number of occasions whilst HIA 127 was in the care of SND 38. There were a number of significant opportunities which we consider were deliberately created by SND 38 in highly unusual and inappropriate situations which should not have been allowed to occur, and which gave SND 38 the opportunity to behave in the way we are satisfied that he did.

51 SND 5228, 5 May, 1989.
52 SND 5450.

153 This leads us to consider the responsibility if any, of the WHSSB for what occurred. We are satisfied that the situation in which SND 38 was able to put forward the suggestion, which was then adopted by the Board, of making SND 38 both the key worker and the "befriender" of HIA 127 should not have been permitted. While we recognise that the WHSSB only had two such situations in its time, one of which resulted in a very successful relationship which produced considerable benefits for the child and led to a relationship with the "befriender" which has lasted for many years, nevertheless such a highly unusual arrangement should have been very carefully and rigorously scrutinised and supervised. In its closing submissions the HSCB asked the Inquiry:

> "To accept the evidence of TL 4 and SND 500 that befriending by a key worker was an exceptional circumstance and that the Western Board did not approve a policy of keyworkers in Nazareth House taking children in residential care home."

154 This submission contradicts the contemporary material which shows that the WHSSB did approve SND 38 taking HIA 127 to his home. In those circumstances the Board has to accept responsibility for the consequences of such a practice being permitted. It is clear to us that SND 38 was allowed to have a very considerable amount of access to HIA 127 over a lengthy period of time, especially after HIA 127 was placed in foster care after he had been at Nazareth House. The Board was aware of this from the complaints of the foster parents at the time, as can be seen from the documents already referred to. We consider that SND 38 was at fault in creating and perpetuating an unprofessional relationship with HIA 127 by being both key worker and "befriender". As his employer the Sisters of Nazareth were primarily responsible for overseeing and managing the work of SND 38 and should have been alert to and questioning of the level of contact he was having with HIA 127 outside the home and often in his own time. They should also have considered more carefully whether it was appropriate for SND 38 to act as key worker and "befriender" to HIA 127. However, the Board had ultimate responsibility for making decisions about and overseeing the care of HIA 127 including the decisions to place him in Nazareth House and in foster care. The Board failed to adequately inform itself about what SND 38 was doing, and appears to have been prepared to take on trust his account of the nature and extent of his contact with HIA 127, when it ought to have exercised very much closer and rigorous supervision over what was clearly a highly unusual relationship which it had approved. **In these**

circumstances we are satisfied that there was a systemic failing on the part of the Western Health & Social Services Board in approving, and then failing to properly monitor, the highly unusual relationship which SND 38 was permitted to have as both key worker and "befriender" of HIA 127, and in not intervening to manage his continued involvement with HIA 127 after his discharge from Nazareth House.

Part Three:

Inspections

155 The Inquiry had difficulty in obtaining as much detail as we would have wished in relation to both Termonbacca and Nazareth House because of deficiencies in the records relating to both homes held by the Congregation of the Sisters of Nazareth, and by various government departments. Most of the records relating to Termonbacca were burnt by the Sisters when Termonbacca closed because they did not have sufficient space in which to store their records. Although some individual records relating to particular children did survive, this was largely a matter of chance. Similarly the files on both Termonbacca and Nazareth House compiled by the Ministry of Home Affairs cannot be found, and it is probable that they were destroyed as part of a routine destruction policy some years ago. When children came into the care of the WHSSB some records for each child were handed over to the Board by the Sisters, but, despite exhaustive searches, some of these files cannot be found.

156 The result of this scarcity of records is that the Inquiry has had to rely on a number of isolated documents which have survived, supplemented by references to Termonbacca and Nazareth House in Northern Ireland Cabinet papers obtained from PRONI. Some Ministry of Home Affairs inspector's reports have survived for other institutions, and these provide some assistance by indicating the type of material which the inspectors looked for. Although the inspection reports themselves have not survived, the records of the Sisters refer to a considerable number of occasions on which Ministry inspections were carried out. By drawing all of these various fragments together it has been possible to recreate a reasonably complete picture of the various forms of inspection process to which both houses were subjected, although it has to be accepted that this is a relatively broad-brush picture as much essential detail does not appear to have survived. Nevertheless, the material which we have been able to obtain has enabled us to draw a number of broad conclusions in relation to the period before the mid-1980s when reports of more detailed inspections instituted by the Social Welfare Advisory Group (SWAG) of the DHSS have survived.

157 The initial level of inspection or supervision of each home was performed by the mother superior. In her evidence Sister Brenda McCall suggested

that each mother superior would carry out a daily visit to all areas within her home, in the course of which she would speak to the children.[53] Very few of the applicants who gave evidence to us had any recollection of such visits, though that would not have been surprising as we would not expect children to remember detail such as that to any significant degree. In any event, we believe that many mothers superior would be seen as remote and authoritarian figures, particularly in the early years, although of course much would depend upon the personality of the individual mother superior. That would appear to be the position to judge by the recollections of SR 147, who described her experiences in early years in a letter written in July 2013.[54] In the letter she said in relation to when she went to Nazareth House between 1968 or 1969 and 1971 "I lived in fear of the Superior who was quite hard, never bid us the time of day or ask us if we had a good day at the collecting when we came in." In 1974 she was sent to Portadown where she referred to the Superior as "quite strict". She went on to say that in 1977 she was changed back to Derry to do the city collecting. Her memories of the mother superior in Nazareth House at that time are revealing.

> "We had another hard Superior! We came home one evening to be told that the Superior had been changed; there were no tears shed! We got a lovely Superior full of compassion, with time to talk to us."

158 Given that a sister formed these views of different mothers superior, it is unlikely that those mothers superior would be able to establish a close rapport with children, or persuade the children to take them into their confidence. Such daily tours of each home provided an opportunity for a mother superior to come across any form of ill-treatment that might be occurring when she entered a room, and we believe that at least some mothers superior must have been aware that some of their sisters did resort to severe physical chastisement on occasion. Although it is an isolated incident, HIA 367 described one evening when the girls were all gathered in the church at Nazareth House for Benediction when they heard screaming coming from outside because one of the sisters was hitting a girl, and "the screaming was unbearable". She described how the reverend mother went out and asked what was going on, and was told that the girl was answering the sister back, whereupon the reverend mother said "not outside the church". HIA 367 was unable to

53 SND 15845.
54 SND 17181.

remember the name of the reverend mother concerned,[55] but episodes such as this must have caused individual reverend mothers to have concerns about the way in which some of their sisters were maintaining discipline. We believe that the need to maintain discipline by a small number of sisters over a large number of children, whether boys or girls, was likely to have led at least some of the mother superiors in both homes to turn a blind eye to what they considered to be the less severe forms of chastisement and punishment which we have found to be administered in both homes.

159 The next level up of internal inspection by the Congregation consisted of periodic visitations of each home by the Superior General of the Congregation (also referred to as the Mother General), or one of her senior assistants. The "visitator" (as the individual was known) was obliged to visit each home every three years or so, and we accept that such visitations were carried out every three years or so from 1928 onwards.[56] In the 1960s a new level of inspection and administration was created with the appointment of regional superiors, each of whom was responsible for the homes in a particular region. The regional superior was obliged to visit each home in her region every three years.[57] The inspections by the superior general or the regional superior alternated, thereby ensuring that every three years or so an external inspection was carried out by a high ranking member of the Congregation. These appear to have been carried out on a regular basis.

160 In her written statement Sister Brenda McCall described the duties prescribed for the visitator.[58] These included moving around all areas of the house concerned, speaking with the residents (including the elderly where appropriate), the children, staff and any visitors whom they meet. The visitator was also required to check the documentation including registers, inspection reports by the relevant statutory authorities and other documentation considered to be relevant. The visitator was obliged to check whether any recommendations or requirements that had been made at any inspection have been followed up, and whether they are being, or have been, implemented. If there were any areas of concern the visitator would give directions that further steps be taken.

55 Day 7 p. 28.
56 These are listed year by year in SND 13948.
57 SND 15849.
58 SND 15849.

In addition, each sister would be interviewed by the visitator and "is encouraged to speak openly and honestly to the visitator about any matter of concern to her in regard to her own position, development or in regard to the running of a house."[59] In her evidence Sister Brenda McCall accepted that the requirement that the visitator speak to the children was one of the requirements that applied throughout the period within the Inquiry's Terms of Reference.[60] The reports follow a standard format, with brief paragraphs under each heading, and the format meant that there was more content about the maintenance of the physical facilities of the house, such as the kitchen, laundry and chapel, and that records were kept up to date, than about the children. Where remarks are recorded about the children they are mainly limited to their appearance and behaviour, and are positive in tone.

161 There are few references to the challenges the Sisters faced in caring for the children although the report of the visitation to Termonbacca on 26 March 1973 records:

> "For many years past, the Sisters had to work under very trying conditions and it was difficult to make a success of their work with the children. It is a credit of all that this project was undertaken at this time and that the new building incorporates the most modern facilities conducive to good childcare."[61]

162 A report has survived for the visitation of Termonbacca held between 26 April and 3 May 1966.[62] This describes how attention was paid to the observance of the Rule and Religious spirit, but also describes in some detail checks that were made on the administration of the home, the kitchens and the laundry, and that the records had been kept up to date. It referred to the farm and to the boys themselves. It recorded that there were 65 boys aged between five and fifteen, and:

> "all are healthy looking, well fed, well dressed and shod and have the voluntary service of many barbers."

The report also refers to attendance at school and recreational activities such as football matches.

59 SND 15850.
60 Day 35, p. 153.
61 SND 14283-14284.
62 SND 14259.

163 In November 1971 advice was provided in the visitation to Nazareth House about the design of the accommodation for the children, saying that "It was suggested that the children should be divided into two groups and that two self-contained flats be provided for them on the top floor."[63] Comments such as these, and the visitation reports themselves, show that close scrutiny of individual houses was exercised at the highest levels of the Congregation, and that the mother general, or a high-ranking member of the Congregation, would suggest the direction in which the particular home should move.

164 Whilst the system of internal inspection was carried out regularly, it did not address every aspect of the management and running of each home in the way that it should have done. These internal investigations by the visitator failed to identify, or ignored, non-compliance with a significant statutory requirement under the provisions of the Voluntary Homes Regulations. The Voluntary Homes Regulations (NI) 1975 replaced the original 1952 regulations, but Regulation 4 (2) of both required two forms of regular monthly inspections to be carried out. The "Administering Authority" (in this case the Congregation) was required "to make arrangements for the home to be visited at least once in every month." This was usually done by the appointment of voluntary visitors who were required to visit once a month. This requirement was ignored by both homes for many years, and even after it was accepted in the 1980s that these steps should be taken, their implementation was not as regular as required by the Regulations. Reports by the SWAG in 1987,[64] 1988[65] and 1990[66] drew attention to the fact that these monthly meetings were not being regularly carried out. For example, it appears that notwithstanding attention being drawn to this in previous years, monthly inspections were not performed in August or September 1989.

165 Had these inspections been carried out by visiting individuals appointed for that purpose as required, then there would have been an additional means for children who had complaints or concerns about the way they were being ill-treated to disclose them in confidence. **The failure of the Congregation to ensure that the statutory requirement was met for so many years is something which we consider constitutes a systemic failing on the part of the Congregation.**

63 SND 14407.
64 SND 9596.
65 SND 9619.
66 SND 9636.

166 As already indicated, a number of children were placed in both Termonbacca and Nazareth House by the welfare authorities of Donegal County Council. See paragraphs 13 to 15 above. Virtually no information has been uncovered which throws any light upon the detailed arrangements made between the Sisters of Nazareth and Donegal County Council in relation to placing children in either home, although HIA 144, who was placed in Termonbacca by Donegal County Council, recalled that a social worker from Donegal County Council came to speak to him, but he was unable to remember exactly when that was.[67] HIA 46 and his brother HIA 121 told the Inquiry that they recall being taken from Termonbacca to Salthill in Co. Galway by an official of Donegal County Council in or around 1960 or 1961. They were placed in an industrial school at Salthill, where they remained until they were discharged some years later. It seems extremely surprising that an official of a local authority from outside the jurisdiction was able to remove children in this fashion from a home in Northern Ireland, even though HIA 46 and HIA 121 were not the statutory responsibility of either local or central government authorities in Northern Ireland. However, given the paucity of evidence in relation to this which we have been able to obtain we merely draw attention to this. For the same reason we are unable to comment as to whether, and if so to what extent, Donegal County Council social services made a regular practice of coming to see children which they had placed in the home in the way described by HIA 144. In its response to the Inquiry's Warning Letter the DoH pointed out that even today, children from the Republic of Ireland may be placed in a children's home in Northern Ireland with the consent of the Republic of Ireland care authority, and where relevant, parents and/or a court. Children from Northern Ireland may also, for example, be placed outside the jurisdiction in special placements in England or elsewhere. In such cases, the placing authority retains responsibility for the child and has the authority to determine the length of the placement and, if necessary, remove the child from the placement. However, our concern was that the removal in this case appears to have been carried on an informal basis without any notice to the relevant authority in Northern Ireland.

167 The other form of local authority informal oversight that we have considered relates to the practice of the appropriate local authorities in Northern Ireland. Prior to the reorganisation of local government in

67 Day 26, pp.59 to 60.

1973, the responsibility for children who were taken into statutory care, as opposed to being placed privately in voluntary homes, remained with the county or county borough welfare committees. As has been pointed out earlier, from the late 1950s onward a small but increasing number of children in statutory care were placed by welfare committees in both Termonbacca and Nazareth House, predominantly by the Londonderry County Borough Welfare Committee (i.e. the committee for the City of Londonderry). The Inquiry has not been able to obtain any records in relation to any form of systematic visit by representatives of any of the county welfare committees before 1969. The only references we have been able to obtain come from the records of the Sisters, which record that in December 1969 the Children's Officer for Tyrone "called to the children in her care".[68]

168 Such contact as there was between any county welfare committee and Termonbacca or Nazareth House relating to the children (as opposed to funding, a separate issue to which we refer later) appears to have been very limited. In September 1966 the secretary of Londonderry Welfare Committee wrote to the Mother Superior of Nazareth House stating that at its meeting on 5 May 1966 the Committee approved a recommendation from the Children's Officer that Nazareth House should be asked to give prior notice of holiday arrangements made for any children accommodated in Nazareth House who were the responsibility of the Committee in order that applications could be investigated. It appears from the minutes of the meeting of 5 May 1966 that the purpose of the investigation would be to see whether the families offering summer placements would be suitable for longer term fostering. There is no record of any response from the Mother Superior, and there is no indication in the minutes of subsequent meetings of the Committee that they received the information they requested.[69] Another reference in the same records kept by the Sisters records that, apparently in December of 1972, there were visits by the Children's Officers from Counties Derry, Tyrone and Fermanagh as well as members of the Derry Development Commission (which had assumed the responsibilities of Londonderry Corporation at the time).[70]

68 SND 13846.
69 SND 13849.
70 SND 13947.

169 Whatever may have been the position by the late 1960s, the absence of any welfare authority records to show that any form of oversight was carried out by local authorities in Northern Ireland of the facilities at either Termonbacca or Nazareth House, and the standard of care given to the children, is striking. We did hear evidence from SND 502 who was employed as a social worker by County Tyrone Welfare Committee, and who visited Termonbacca in that capacity in order to see one of the children placed there by that committee in 1964 and 1965.[71] Although the absence of evidence makes it more difficult to draw any conclusions as to the nature of any interest shown by county welfare committees in children they placed in either Nazareth House or Termonbacca prior to the reorganisation of local government, the fact that only references to visits by County Tyrone Welfare Committee employees have survived is significant. The lack of any reports in the documents relating to the Londonderry Welfare Committee records in PRONI suggests that the City and County Welfare Committees may well have taken little if any interest in the children whom they placed in Termonbacca and Nazareth House from the late 1950s onwards. Had there been proper interest in at least the conditions in which the children whom they were placing were being brought up we would have expected references to these to have survived, and to be incorporated in the records from the county welfare committees which are held in PRONI. The absence of any such references confirms our view that there was little, if any, effort by the relevant county welfare committees to inform themselves of the conditions in which the children in their care were being looked after prior to the late 1960s. **We consider that the apparent failure of the relevant county welfare committees to regularly visit the children in their care whom they had placed in Termonbacca and Nazareth House represented a significant failing in their obligation to inform themselves of the progress of, and the conditions in which, their children were living in these homes. We regard this as a serious institutional failing on their part.**

170 The situation so far as Londonderry County Borough Welfare Committee was concerned appears to have changed somewhat with the appointment of SND 483 as a children's officer in 1969. That SND 483 chose not to come and give oral evidence to the Inquiry, is something which we regret. As she resides outside the jurisdiction we had no power to compel

71 Day 31 pp.36 and 37.

her to attend, nevertheless we have no reason not to accept much of the account which she gave in her witness statement.[72] She described the department which she joined as having a system which appeared to be completely unregulated, indeed she was the first person to work in that department who had any social work qualifications. She appears to have interested herself in the situation regarding the placement of children in Termonbacca because she was approached by families who sought approval from "the welfare" so that they could adopt boys in Termonbacca. On looking into the situation she found that none of the boys in Termonbacca had any involvement with the welfare system, nor did they have an assigned social worker. She states that she put in place an arrangement whereby if a family arrived at Termonbacca and sought to place a child there, the sisters would contact her and she would then carry out an assessment to see whether or not the child should be taken into care. She states that if she decided that they should be, she put the matter before the City Council, and if the child was taken into care a weekly payment of £2 10s was made to the home by the Council for the maintenance of each child. She described how she then visited Termonbacca when she could, and as the children were normally at school she would speak to the sisters. These were normally unannounced visits, and she did see the younger children who were underage on her visits. However, her interest in Termonbacca only related to those boys whose placement she had sanctioned. She remained in a similar role, but responsible for a different geographical area, until she left the WHSSB to take up a position with the Roman Catholic Diocese of Derry. This evidence confirms the finding which we have just expressed, and indicates that from 1969 onwards the Londonderry County Borough County Welfare Committee, and its successor the Derry Development Commission, did take a greater interest in the children it had put in care. It may not be coincidental that the references to visits by the County Tyrone Welfare Committee Children's Officer in 1969 are also recorded.

171 By 1970 or 1971 there was an increasing practice to place children in Termonbacca on the part of the Londonderry County Welfare Committee, because the evidence of SND 484 was that she placed one of the applicants in Termonbacca in 1971 when she was a social worker with the County Londonderry Welfare Committee. It is striking that her conclusion about the children was that whilst they appeared safe and

72 SND 15901 and following.

well-cared-for, they were probably very institutionalised, and this was going to be difficult for them in later life.[73] She found at that time that social workers could come and go to Termonbacca as they wished, and whilst her view of the children during her earlier visits to Termonbacca was that they seemed quite subdued, at the time of her visit to Nazareth House in the 1980s the children seemed to be more spontaneous and to be enjoying themselves more, and the atmosphere was better.[74]

172 By the mid-1970s there was a much greater degree of contact by what was now the WHSSB with Termonbacca. TL 19, who started visiting Termonbacca in 1975, felt that the environment was a warm and caring one, and that although it was a very large establishment, and one which might well have been intimidating for children, the caring and the atmosphere were welcoming, although he did recognise children could become institutionalised in that setting.[75] Nevertheless, the practical value of such visits was reduced because meetings between social workers and children took place in either the parlour or in a corner of the recreation room, neither of which provided a suitable environment to have a confidential talk with the children.

173 We consider that the evidence of TL 19 revealed two significant failings on the part of the Board in so far as Termonbacca was concerned. His evidence was that he did not remember the WHSSB ever considering taking children into care by virtue of the provisions of Section 103 of the Children and Young Persons Act (Northern Ireland) 1968 where the children had been placed privately in Termonbacca.[76] Nor were there any arrangements in place throughout the 1970s and 1980s whereby the Board would make arrangements to befriend children who had been discharged from voluntary care on reaching the age of sixteen, despite there being a clear duty upon the Board to do so under Section 131 of the 1968 Act.[77]

174 Although the evidence of SND 502 was that when the WHSSB was formed in 1973 it was short of staff,[78] her evidence was that the WHSSB worked on the principle that it considered children for admission into statutory care who had been placed in Termonbacca voluntarily only

73 Day 23, p. 36.
74 Day 23, p. 78.
75 Day 24, pp. 14 and 15.
76 Day 24, pp. 22, 23 and 30.
77 Day 24, pp. 32-34.
78 Day 31, p. 27.

when their existence was brought to their attention,[79] in other words the Board had a reactive and not a proactive approach in this context. However SND 502 said that she "would have been shocked if there were children going in and out of care (i.e. in Termonbacca) that we didn't know about, because we had an overall responsibility."[80] The voluntary sector in general, and therefore Termonbacca and Nazareth House in particular, valued their independence, and that independence meant that their ability to function effectively and independently was accepted by both central and local government for reasons that we should consider shortly. Nevertheless, even allowing for administrative difficulties and the internal pressures created by the need to create a new service, we consider that the Board could and should have done more to inform itself about the arrangements that were being made for the reception into voluntary care of children in a geographical area for which it was responsible, so that the Board could consider whether any of these children should be accepted into statutory care.

175 Nor does the Board ever appear to have concerned itself with whether or not the Sisters in either home were complying with their statutory obligations to put in place their own monitoring and inspection procedures,[81] although monitoring and inspection were a function of the relevant central government department, initially the Ministry of Home Affairs, and later the Department of Health & Social Services (the DHSS).

176 We now turn to inspections carried out by the Ministry of Home Affairs, and later by the DHSS. So far as the Ministry of Home Affairs is concerned, the absence of files means that that the Inquiry has been dependent upon the evidence of inspections contained in the records of the Sisters and fragmentary reports and references that have survived elsewhere. We are satisfied that there were frequent and regular, apparently annual, inspections of both Nazareth House and Termonbacca by inspectors of the Ministry of Home Affairs throughout the 1950s and 1960s, and these continued in a different form when those responsibilities were transferred to the DHSS after the imposition of direct rule and the reorganisation of governmental and local authority responsibilities in the early 1970s. There are numerous references

79 Day 31, p. 51.
80 Day 31, p. 59.
81 Day 31, pp. 63 and 64.

in the Sisters' own records to such visits, all of which indicate they received positive feedback about the care they were providing, and a small number of inspection reports have survived. Therefore, we conclude there were ample opportunities for the state to assure itself of the quality of care being provided in both these homes.

177 At an early date it was decided that these inspections would be carried out by an inspector employed for that purpose by the Ministry, and by the early 1960s the inspections were carried out jointly by an inspector from the Ministry of Home Affairs and a doctor from the Ministry of Health and Local Government. This was a sensible and progressive arrangement, but the question arises as to the quality of the inspections. In this context a seminal document is a three-page, typed, report prepared by Miss Kathleen Forrest, one of the Ministry of Home Affairs inspectors, on 28 April 1953. She carried out many such inspections in the ensuing decades. Her April 1953 report[82] gave what she described as "some brief summary impressions of the different Voluntary Children's Homes." As can be seen from the entirety of this document she focused on not merely the physical facilities provided at various homes but on the size and quality of the staffing and on the general atmosphere. She identified Termonbacca as "very institutional" and "short of staff", and she described Nazareth House as having the "best play equipment of any of the four Nazareth Homes, at any rate for toddlers. Still very institutional." She then proceeded to comment on the four Nazareth House homes, i.e. Nazareth Lodge, Belfast, Nazareth House, Belfast, Termonbacca and Nazareth House, Derry in the following terms:

> "The children in these 4 Homes especially have nothing like a normal upbringing. They must feel unloved as it is just not possible for the number of staff to show affection to such large numbers of children. They can know little or nothing of the world outside, (as with one exception school is on the premises), and must be unprepared for it, either in character or knowledge. I find these Homes utterly depressing and it appalls me to think that these hundreds of children are being reared in bleak lovelessness. This is not meant entirely as criticism of the staff, but their task is impossible."

She concluded the report with the following words:

> "In short, I think we must press for complete overhaul of the whole set-up of these Homes, and assist them in every way possible."

82 HIA 1462 to HIA 1464.

178 The comments by Miss Forrest just quoted are of the utmost importance as they are central to a consideration of the way in which inspectors from the Ministry of Home Affairs subsequently carried out their inspections, and how the Ministry and the Government of Northern Ireland at the highest level approached the question of funding of these two homes in succeeding decades. Miss Forrest was not alone in her assessment in 1953 that the standards of accommodation and care in Roman Catholic voluntary homes left a lot to be desired, because a year later we find the following comments written on a paper showing, inter alia, that of 787 children in voluntary homes, excluding children placed there by welfare authorities (in other words voluntary placements) 688 were Roman Catholic. The writer commented:

> "It could be argued from these figures that the RC community have such a keen appreciation of what is due to deprived RC children that they prefer to bear a greater share of responsibility for their maintenance than Protestants are prepared to do for deprived Protestant children. But it would not be a very strong argument, I'm afraid, *unless the all-important questions of standards of accommodation, etc. are ignored.*"[83] (Emphasis added)

179 As we have already stated, the Termonbacca files no longer seem to exist, but a crucial document has survived in the form of a letter from an as yet unidentified senior civil servant to his counterpart, L.G.P. Freer in the Ministry of Home Affairs.[84] This letter deserves to be considered in its entirety. It refers to a file and to a minute which Freer appears to have sent to his staff (neither of which have been found). The writer of this letter makes reference to his experience in the equivalent department of the pre-1922 Local Government Board, and says that he is returning the file "about the inspection of the voluntary organisations." He says:

> "I would say that I wholeheartedly agree with your minute to your staff on the subject, and I disagree equally wholeheartedly with the action that they took on your minute. I think they took you up completely wrongly, and that they have gone much too far, and made much heavy weather out of the whole business."

180 When one reads the extended account he gives of the manner in which staff of the Local Government Board carried out inspections it is clear that he is suggesting that the inspectors should not concern themselves

83 SND 7467.
84 HIA 1586 and HIA 1587.

unduly with the manner in which an institution was run by the responsible organisation. Towards the end of the letter he says:

> "In other words, I think if a Government Department has had any hand in paying grant it ought to display a reasonable interest in how the place was run, but unless there is a definite responsibility on them for ensuring that it is managed in the best and most economical way possible I don't think they ought to undertake this responsibility.
>
> I imagine these are exactly your views on the subject.
>
> However, in the present case, what has been done has been done, and so if I were the responsible person (which thank God I am not) I think my inclination would be just to see that we did not get more deeply involved than we are at the moment."

181 We consider that the tenor of this letter, and in particular those parts quoted above, indicates that an influential civil servant was drawing on his own pre-1922 experience to disagree with the view of their responsibilities that appears to have been adopted by the inspectors, and to agree with the observations of his colleague. We consider the appropriate inference to draw is that he was recommending to his colleague that inspectors should not become "more deeply involved" in the manner in which the institution was run; in other words, he was advocating a stance that would concern itself merely with seeing that minimum standards were observed, and not become involved in trying to persuade the institutions concerned to improve the way in which they looked after the children in their care. In view of some striking omissions from subsequent reports which have survived we consider that this appears to have been the stance which the Ministry thereafter adopted, and that they did not follow the recommendation by Miss Forrest that the Ministry should "press for complete overhaul of the whole set-up of these Homes, and assist them in every way possible."

182 That a less interventionist approach appears to have been adopted by the Ministry, at least so far as the inspectors' reports are concerned, may be seen from the terms of two relatively brief but informative reports which have survived. Miss Wright (a colleague of Kathleen Forrest) reported on her inspections of Termonbacca in July 1960[85] and Nazareth House in September 1960. Neither of these otherwise detailed reports make any reference to the question of staffing and the

85 SND 6174.

problems related to it that Miss Forrest had identified. This suggests that a deliberate policy of not concerning themselves with staffing had been adopted by the inspectors. Dr Harrison accepted that the question of staffing in the home was a fundamental issue which should have been addressed.[86] As she pointed out in her answer in relation to a question from Inquiry counsel in relation to the report of the 1961 inspection of Nazareth House, "There certainly is an emphasis on material standards and physical well-being as opposed to emotional or development needs."[87] She accepted that what was missing was any consideration of the consequences to the emotional needs of the child if the staffing of the institution concerned was inadequate.[88]

183 Whilst the absence of references to staffing in later reports suggest that what was being done in practice was to adopt what Dr Harrison categorised as "a hands-off approach",[89] there was another deficiency in the reports. Not only did they fail to look in a comprehensive way at the needs of the children, but they did not detect that there was a failure to deal with the statutory requirements under Section 103 of the 1950 Act. As Dr Harrison conceded, and we accept, there is no evidence that significant changes were made in the attitude taken by the Ministry of Home Affairs despite the comments made by Kathleen Forrest in 1953,[90] nor is there any evidence of the Ministry adopting a proactive approach.[91] This was a very disturbing situation because, as Dr Harrison accepted when Inquiry Counsel put it to her, Miss Forrest's report "should have set off major alarm bells in the Ministry of Home Affairs."[92] As Dr Harrison agreed, there is nothing to show that in later years the staffing issue in either home was addressed by the Ministry of Home Affairs.[93]

184 Not only was the failure to deal with staffing issues an indication of an unwillingness by the Ministry of Home Affairs to take a proactive approach on this subject, but the failure to check whether basic statutory requirements such as those relating to Section 103 of the 1950 Act were being met was a clear defect in the manner in which the inspection

86 Day 38, p. 22.
87 Day 38, p.25.
88 Day 38, p. 25.
89 Day 38, p. 23.
90 Day 38, p. 41.
91 Day 38, p. 42.
92 Day 38, p. 45.
93 Day 38, p. 53.

was carried out. We consider that this should have been a question that was raised in the 1960 reports of Miss Wright because of an episode the year before when it emerged that two children were working on a farm in the country and the home had not notified the Ministry as it was required to do under Section 103. This is a further illustration of the justification for the point which Dr Harrison made to the Inquiry that the then Department of Health & Social Services accepted in the light of the report by the Hughes Inquiry in 1986 that "the frequency and rigour of its inspection programme left a lot to be desired" between 1960 and 1980, and, she commented, "one can assume then that there was certainly no difference in the 1950s, that, in fact, those deficiencies were prevalent during the 1950s."

185 Although the inspection regime responsibility was placed with the SWAG of the DHSS in the early 1970s, and whilst the reports which were prepared thereafter were very much more extensive and informative than the shorter earlier reports prepared by the inspectors from the Ministry of Home Affairs, nevertheless not all of these reports reached a satisfactory standard. In the 1983 report, which commences at SND 9976, there was no reference to the fact that the Congregation as the "administering authority" was not complying with the requirements of the Voluntary Homes Regulations that required monthly visits from voluntary visitors. Dr Harrison found that to be a very surprising oversight in the 1983 inspection,[94] and we agree. By this time Termonbacca had closed and this report was of an examination of Nazareth House by SWAG, nevertheless it demonstrates that as late as 1983 central government inspections of Nazareth House, and the earlier inspections of Termonbacca, failed to identify that these important requirements were not being met. Not until new guidance was issued by the Department in 1985 did subsequent SWAG reports on Nazareth House refer to this requirement. Even when it was mentioned, a relaxed attitude appears to have been adopted by the inspectors because they merely made anodyne recommendations that compliance with the regulations should be improved. It is obvious, since these recommendations were made in several successive reports, that the Sisters were not complying with the recommendations.

94 Day 38, p. 29.

186 Although in other respects the later inspections by the DHSS were, as we have just said, comprehensive in most respects so far as we can judge from the limited examples that have survived in relation to Termonbacca and Nazareth House, and the early reports in the 1960s were quite detailed, we are of the opinion that the inspection regime that operated from 1950 until the mid-1980s was deficient in a number of respects. First of all, despite the clarion call of Miss Forrest's 1953 report, we can only conclude from the absence of references in the reports to staffing in the decades thereafter that the Ministry of Home Affairs decided not to concern itself with this, vital indeed, fundamental aspect of the management of the homes in question. **This failure was a significant systemic failing on the part of that department.** In addition, the inspections which were carried out for many years failed to pick up that the monthly voluntary visiting requirements of the Voluntary Homes Regulations were not being complied with in either home. Nor was attention paid with sufficient determination to whether or not the notification requirements of Part 1 of the 1950 Act were being complied with by the Sisters of Nazareth. **Although we acknowledge that the inspection regime developed in the 1980s was a much more satisfactory regime than had been in place before that, we consider that all of these amount to a significant systemic failing on the part of the relevant government departments until the mid-1980s.**

Funding

187 The arrangements for the funding of Nazareth House were different from those relating to Termonbacca. Accounts that have been provided for Nazareth House for 1954[95] and 1955[96], confirm the dependence on alms and legacies as the home was dependent upon the proceeds of the daily collections carried out by sisters specifically allocated to collecting money door to door in both the city and country areas. In addition to legacies there were presumably large donations of money or gifts in kind of the type referred to earlier. When a child was placed in the home by a parent it was expected that a weekly or other payment would be made by the parent, but the reality appears to have been that in many such instances payments were not made at all, or were discontinued after a period of time. We accept that the main burden of providing for the

95 SND 7443.
96 SND 7442.

children rested on the Sisters' own resources. Accordingly, it became clear in the 1950s in circumstances which we will describe later, that Nazareth House would have to look either to the mother house in Hammersmith for financial support, or to the local authorities in the form of county welfare authorities, or to central government for financial aid for both capital and revenue expenditure. As there were few children placed by local authorities in Northern Ireland in Nazareth House at this time it is likely that the amount received under this heading for each such child was modest. We have already referred to the number of children placed in the home by the County Donegal County Council, but there is little evidence as to how much was paid for each child, although there are fragmentary records which suggested that some form of weekly or annual payment was made by Donegal County Council for such children.

188 The position at Termonbacca was somewhat different. The sisters at Termonbacca did not take part in collecting themselves but, as we have already recorded, by the 1970s they were receiving £1,000 a month from the proceeds of the collections carried out by the sisters from Nazareth House. It seems that this was a long-standing practice. Accounts for Termonbacca for the years 1954, 1955, 1956 and 1957 show that in each of these years £3,200 is shown as income from "Alms". Given that the same amount is shown each year and described as "Alms" we infer that this may well have been money provided on a regular basis to Termonbacca by Nazareth House. In addition there were various payments made by parents when children were placed in the home and as children began to be placed by the county welfare committees regular maintenance payments were made in respect of those children also. It is unclear the extent to which Termonbacca benefitted from individual cash donations as the figures vary in each of the four years, from £1,313 in 1954 to £6,377 in 1956.[97] These figures would suggest that regular and substantial monetary support was given to Nazareth House by the Roman Catholic community. However, the principal difference between the funding arrangements for Termonbacca and Nazareth House related to the farm run by the Sisters at Termonbacca. The farming enterprise appears not to have been successful in the early to mid-1950s to judge by the entries in the accounts for 1954, when £2,347 is shown as the proceeds of "auction of cattle and implements", and in 1955 £223 is shown as the proceeds from the "sale of milking machine". In the years

97 SND 5838.

1954, 1955 and 1956 no income is shown as coming from the farm, but in 1957 the income is shown as £700, which suggests that farming had been resumed at Termonbacca, albeit perhaps on a more modest scale than before. Certainly by the early 1960s there are references in the Termonbacca records produced in relation to the farm which would suggest that it was on a sounder financial footing. The Visitation Report of 1962 commented that "The farm which had hitherto been a great liability is now well organised, and there are evident prospects that it is going to be adequately productive."[98] In February 1964 permission was given by the mother general to erect a building for the boys at the cost of £25,000, and she granted permission to transfer £3,000 on deposit, and £1,000 from the farm account, to help towards the proposed building. The same entry relates to receiving a cow subsidy of £240 for the first time, and it is recorded that "the subsidies are a big help to the farm".[99]

189 Both Nazareth House and Termonbacca were regarded as being in a semi-autonomous relationship with the mother house. Essentially this meant that each had to stand on its own feet financially, although a close rein was kept on the local finances by the mother house, with even relatively modest items of expenditure requiring the approval of the mother general, as in 1967 when she gave permission for the purchase of a new car. Loans were made from time to time from the mother house, which it was expected would be repaid when the house in question was in a position to do so. For example, in November 1969 it was agreed to pay off "£1,000 off our debt to the Mother House".[100] In the Termonbacca accounts already referred to it appears that £10,300 was transferred in the form of loans from Hammersmith to Termonbacca in the years 1953 to 1957: £5,000 was sent in 1953, although there are no accounts available for that year; in 1954 a loan of £2000 was made by the mother house; in 1955, £200 was received in this way; and in 1956 £3,000 was received by way of loan from the mother house.[101] Therefore in the years 1954 to 1956, of a total income of £39,078, £5,500 came from the mother house, or 14.08% of the total income of Termonbacca.

98 SND 14250.
99 SND 14254.
100 SND 14272.
101 SND 5838.

190 It is clear that both Termonbacca and Nazareth House were heavily dependent upon the generosity of individuals, businesses and other donors in Londonderry and the surrounding area, and in the 1950s at least it appears that Nazareth House subsidised Termonbacca to some extent as well. Whilst Termonbacca was able to rely in part upon its farming activities these do not appear to have been successful in the early 1950s. Both homes were therefore in a parlous financial position, and if their own resources were inadequate to fund either substantial capital expenditure to replace or repair buildings, or to engage more staff, and the mother house could not provide extra money, their only option was to seek financial support from central government or the county welfare committees. Both homes did so in a number of instances, which we now consider.

191 Applications were made by Nazareth House and Termonbacca in the 1950s and 1960s for capital grants from the Ministry of Home Affairs. A number of such grants were made, and where a grant was made to a voluntary home for such capital work under Section 118 (1) of the Children and Young Persons Act (Northern Ireland) 1950 local authorities were then required to contribute 50% of the grant by the Ministry. This took the form of a levy by the Ministry on each welfare authority, the exact contribution being proportionate to the population in the county or county borough concerned. Thus when a grant of £800 was made towards the cost of improving the kitchens at Termonbacca, this, together with 50% of a grant of £100 during the same period to Glendhu Childrens Hostel, Holywood Road, Belfast, was then recouped from each authority. Londonderry County Borough was required to repay £16 8s 10d, and Londonderry County £34 12s 3d. Other welfare authorities across Northern Ireland were also required to contribute, and this requirement was one which gave rise to considerable opposition on the part of the welfare committees. Their opposition was described in a Ministry of Home Affairs memorandum in April 1953[102] as "no taxation without representation" because these amounts had to be found by county welfare committees from local taxation in the form of the rates raised by their parent county councils. The welfare committees objected to this because they said that some committees had to contribute towards services which were not being provided in their area, and therefore from which they received no benefit. In addition they felt that

102 SND 7484.

they were paying for services being provided by other bodies for the care of children who may not have passed the care threshold imposed by the welfare committees in relation to children taken into care in their own homes. Finally, they had no say in how the money was spent. However, although the Ministry decided not to give in to this argument, it did set up the Childrens Home and Training School Committee, commonly known as the Maconachie committee after its Chairman, Miss Bessie Maconachie MP. The committee was set up in May 1956 "to advise the Minister whether or not the circumstances appear to be such as to call for special financial assistance from public funds under the Act". The committee contained representatives of the churches, the Child Welfare Council and local authorities.[103]

192 So far as capital funding is concerned, an application was made by Nazareth House for a grant towards the provision of a new play hall, and the cost of upgrading the fire precautions. The application for the play hall appears to have caused the Ministry considerable political difficulty to judge from letters written by the Unionist MP for the City of Derry, E.W. Jones QC MP, to the Minister of Home Affairs, G.B. Hanna QC MP.[104] Jones was strongly opposed to what he refers to as the "proposed grant to the Nazareth Home in Londonderry", saying:

> "On further reflection about this matter I am even more strongly convinced that this Grant should not be made at any time but particularly at the present time when public monies should be so carefully guarded."

He went onto say that he felt so strongly about the matter that he felt it should be put to the Prime Minister and before the party.

193 In a memorandum by the Minister of 1 February 1956[105] he reviewed the practice to date in making grants under Section 118 of the 1950 Act and observed:

> "In the circumstances prevailing in Northern Ireland, grants to voluntary homes must necessarily be a source of great political danger. In my opinion it is unwise to increase the difficulties for this Department in the political field. The whole matter will have to be reviewed and I would like to have suggestions as to possible courses which we could adopt."

103 SND 6019 and 6020.
104 SND 7504 and SND 7503.
105 SND 7415.

Whilst the nature of the "great political danger" is not specified, it has to be remembered that the political atmosphere in Northern Ireland was particularly tense at the time; there had been attacks by republican terrorists on Gough Army Barracks, Armagh in June 1954, and on Rosslea RUC Barracks in Co. Fermanagh in November 1955. In December 1956 the IRA launched a terrorist campaign in Northern Ireland which continued for some years. Nevertheless, notwithstanding the clear political nervousness demonstrated by these documents, a substantial grant was made for the play hall and towards the cost of the fire precautions, amounting to £5,000 for the play hall alone.

194 This grant was made under Section 118 (1) of the 1950 Act, and in 1957 an application was made by Termonbacca to Londonderry County Borough Welfare Committee for a grant and a grant was made of £250. No doubt emboldened by this, in 1958 E. McAteer, a nationalist MP, applied to the Londonderry County Borough Welfare Committee for grants for both Nazareth House and Termonbacca. The Welfare Committee agreed to make a payment of £1,000 to Termonbacca,[106] but this required approval by the Ministry of Home Affairs and the matter was referred to it. This caused the Ministry to look into the whole position of grant aiding voluntary homes under the provisions of Section 118 (2) of the 1950 Act. It consulted the Home Office, and was advised that it took the same view as the Ministry proposed to take, namely that it did not regard Section 118 (2) as being a proper method for grants to be made for what were effectively revenue purposes. The reasoning behind this was set out at length in a letter to Mr. McAteer dated 3 October 1958,[107] in response to a letter from Mr. McAteer at an earlier stage of the correspondence dated 30 September 1958.[108] In that letter he took issue with the Ministry's interpretation of the extent of its powers under Section 118 (2) and concluded by saying:

> "All that is needed here is a right act of will. Be assured that the public purse is on a very good bargain in getting £12,000 of first class Welfare work for a mere £1,000."

195 So far as contributing towards the cost of staffing and other costs, which would now be regarded as revenue expenditure, this remained the government's position for many years. This was despite a

106 SND 12978.
107 SND 6001 and 6002.
108 SND 6003.

recognition within the Ministry, earlier referred to, that the standard of accommodation left a lot to be desired, and Kathleen Forrest's warning about the inadequate staffing. The Ministry accepted that there was by no means a clear intention to limit the provision of assistance under Section 118 (2) in a way that would prevent financial aid being given to voluntary homes for staffing costs, just as it recognised that it would relieve the cost which would ultimately fall on the public purse if voluntary homes were assisted in this way. As early as 1954 the Ministry recognised that:

> "Giving such grants was more economical than direct provision of new Homes by Welfare Authorities, as the Voluntary Homes do not charge full rate, as they have their own voluntary fund and labour. In fact there was the question as to whether there should not be a halt to the provision of Statutory Homes and the using of more Voluntary Homes."[109]

Not only that, but at the same meeting it was suggested that:

> "Not all Voluntary Homes were up to the standard of Statutory Homes and it was difficult in some cases to obtain progressive reports as to the children accommodated in some of them."

196 In July 1958 the matter had been put to the minister in the following way:

> "Myself, I have always thought that the sub-section is intended to go rather further, and that if the welfare authority feels that the managers of a children's home in their area are, in fact, helping and relieving them indirectly of looking after children, some of whom would otherwise fall to be taken into care and perhaps housed by the welfare authority, and if that Home is finding it impossible to make ends meet it is a legitimate and proper thing, and incidentally good business, to make some contribution to the Homes' general funds by grant under Sub-section (2)."

197 It is apparent that the Ministry chose to adopt a narrow interpretation of its powers to make grants to support the general funds of voluntary homes such as Nazareth House and Termonbacca, when it could, by "a right act of will" as urged upon it by Mr. McAteer, have justifiably taken a more generous view of the construction of the Act. Such a

109 SND 7475.

view would have enabled it to make payments which would have had the benefit of providing money for Nazareth House and Termonbacca to employ lay staff to improve their staffing ratios, whilst ensuring that the public purse did not have to pay as much to support children who would otherwise have to be supported by it if the children were not being taken into Termonbacca or Nazareth House because the Sisters were unpaid and worked long hours.

198 The result of the narrow view taken by the Ministry, whilst it was in accordance with Home Office practice in England at the time, was that the Sisters of Nazareth were unable to find the money which was required to improve their staffing ratios. If such financial support had been forthcoming, it is our view that many of the abuses due to, or substantially contributed to, by the absence of sufficient qualified staff could have been avoided.

199 In reaching this conclusion we have not ignored the problem created for itself by the Congregation through its practice at that time of not disclosing its overall financial position. As several of these memoranda observed, when applications were made for both capital and revenue grants both the Home Office and the Ministry of Home Affairs asked to see the accounts of the parent organisation in order to ascertain whether or not the organisation as a whole, and not merely the local institution by whom the application for grant aid was made, could meet the cost of running the local home.[110] The difficulty which the Congregation created for itself was that it was not willing to reveal its overall resources, and therefore the Ministry of Home Affairs adopted the same view as the Home Office in London when such applications were made: they asked to see the accounts of the Congregation as a whole, and the applications were then withdrawn. Sister Brenda McCall conceded that at that time the Congregation's policy was to maintain complete secrecy in relation to its financial affairs, and by failing to provide the information which the Ministry of Home Affairs sought the Congregation made it difficult for itself to obtain the support it was seeking.

110 SND 6007-6008.

200 The consequence of this was that the Ministry refused to approve the grant of £1,000 which the Londonderry County Borough Welfare Committee had proposed to make to Termonbacca in September 1958.[111] This impasse between the Sisters and the Ministry of Home Affairs over the question of accounts continued for some years. In February 1964 plans for a drastic change in the nature of the accommodation provided at Termonbacca so that small units could replace the existing dormitories were approved by the mother general.[112] An application for grant-aid for this large project was duly made to the Ministry of Home Affairs with the support of the Ministry inspectors. The Sisters noted in their records that:

> "Doctor Simpson and Miss Hill paid us a visit, February 4. Both were very pleased with the boys and most anxious that we would build dormitories as more sleeping accommodation was needed, said they would say so at Stormont and hoped we would get a Grant."[113]

201 The application came before the Northern Ireland cabinet in July 1964 and there were again discussions about the policy of asking the Congregation for details of its accounts and the refusal of the Congregation to provide this information. It was decided to seek further information because substantial sums were involved.[114] However, it is noteworthy that the Minister noted in his memorandum to the cabinet that this information was not sought in Scotland "on the assurance that the houses were required to be self supporting."[115] In the supporting memorandum the Minister drew attention to a number of relevant factors, two being of particular relevance:

> "that in a special Northern Ireland circumstance it could safely be assumed that quite a large number of the children voluntarily accommodated in homes like Termonbacca would, if these homes were not available, have to be accommodated at much greater expense by the welfare authority; that there is no doubt that the children in this home have at present an undesirably low standard of accommodation and there is at the very least no guarantee that the right sort of improvements, or indeed any improvements, will be made if there is no possibility of grant aid."

111 SND 6004 and SND 12978.
112 SND 14254.
113 SND 13946.
114 SND 6017.
115 SND 6013.

202 The matter was referred for further investigation and came back before the Cabinet in January 1965. The Cabinet was told that the Sisters of Nazareth "again firmly refused to supply such details".[116] The Cabinet decided to offer 25%, and it appears that this offer was communicated to the Sisters,[117] but it must have been declined by them because it was less than would enable them to complete the building with their own resources. It was not until October 1966 that the matter came back before the Cabinet, when it was pointed out that while the Minister "was not particularly happy about extending the principle of State grants to voluntary homes, the present proposal would undoubtedly result in considerable economies to the public purse".[118]

203 However, the Government did not change its position, and it was not until February 1970 that the matter came before the Cabinet again. The then Minister of Home Affairs, R.W. Porter QC MP, noted in his memorandum that:

> "In March 1966 my Department asked St. Joseph's to consider the matter further and in particular to consider the possibility of introducing more enlightened methods of care. The proposals so far put forward have been limited because of cost and my Department was concerned lest these would perpetuate the existing system of segregation of sexes in dormitory sleeping.
>
> After discussion with my Department St. Joseph's has produced acceptable plans on modern lines for new house units where children will live with staff. The cost is estimated to be £93,500 and a formal application for a grant of 50% of the cost has been made."[119]

204 There was a lengthy discussion of the relevant matters in the memorandum, and it was pointed out that:

> "…it is difficult to argue that the accounts of an organisation covering some sixty or seventy foundations scattered throughout the entire world and covering a wide range of social need have any significant bearing on a children's home in Londonderry."[120]

116 SND 6025.
117 SND 14258.
118 SND 6030.
119 SND 6035.
120 SND 6036.

205 The Minister recommended a grant of 50% and this was approved. The offer was subsequently made,[121] and the work put in hand. Over the next two years the work continued with stage payments being made by the Ministry as the work progressed, and the building was formally opened on 21 November 1972.[122] Shortly afterwards a further grant of £12,500 was made by the Ministry of Home Affairs to Termonbacca to help with the running costs.[123]

206 The change of approach by the Ministry was a welcome, but extremely belated, recognition of the need for substantial contributions from public funds to the capital costs of making changes at Termonbacca. Whilst the attitude of the Congregation in not producing its central accounts created a significant obstacle to the Government making the necessary contribution towards the building, had a more enlightened and realistic attitude been adopted much earlier by the Northern Ireland Government, a position it knew had been adopted in Scotland, then this building could have been available for children six years earlier than it was. That would have enabled essential improvements to be made to the physical facilities at Termonbacca, improvements which the Government knew for many years were needed, and which would have significantly improved the care of the children in Termonbacca.

207 We consider that the Ministry failed to do enough to pro-actively encourage the Sisters to convert Termonbacca into smaller units of the type recommended by the 1952 Home Office memorandum, despite being aware from the reports of its inspectors, and from other information made available to it, that the children in Termonbacca were existing in outdated accommodation with inadequate numbers of staff to look after them, conditions significantly inferior to those enjoyed by children in the statutory sector. Had it done so, that would have gone a long way towards reducing the opportunities for abuse which were a feature of the earlier structure. **The length of time that it took the Government to bring itself to make the only sensible decision open to it was such as to amount to a systemic failing on its part, even though some of the responsibility for that state of affairs must still be borne by the Congregation because of its unwillingness to produce its accounts when an application was being made by it for a grant of a very substantial sum of public money.**

121 SND 6131.
122 SND 18046.
123 SND 18046.

Post 1972 funding for Termonbacca and Nazareth House

208 Capital funding for Termonbacca does not appear to have been a problem after the completion of the new build in 1972. Nazareth House then embarked on a similar programme in order to transform the existing dormitories into smaller family units by converting the second floor of Nazareth House into two flats in 1972,[124] and similar work to create a third flat was completed by May 1974.[125] No suggestion was made that this work at Nazareth House required any government help, and we therefore infer that the Sisters were able to fund this work themselves. Similarly there appears to have been no call upon government funding for any other work carried out at Termonbacca before it closed in 1982.

209 However, lack of funding for extra staff continued to be a significant problem for Termonbacca until it closed in 1982 and for Nazareth House for sometime thereafter. Funding for extra staff came under the heading of revenue funding, i.e. for day-to-day expenditure, and after the reorganisation of local government in 1973, which resulted in the creation of the WHSSB, any additional public funding for extra staff for either Termonbacca or Nazareth House had to go through the WHSSB. The WHSSB then had to obtain that funding from the DHSS and, as we shall see, Nazareth House continued to experience significant problems in obtaining extra funding until shortly before it closed.

210 A complicating factor was that from the early 1970s fewer children were privately placed in either Termonbacca or Nazareth House. As a result the number of children in statutory care increased in numerical terms, and as a proportion of the overall number of children in each house, because the overall number of children being admitted to care was declining at the same time. The combined effect of these factors was that both houses eventually became completely dependent upon the WHSSB. Eventually all of the children in both were in statutory care and had been placed there by the Board. As was the practice by voluntary homes throughout Northern Ireland, each house then charged the Board a set amount for the care of each child. The Board therefore paid Termonbacca and Nazareth House to look after some of the Roman Catholic children taken into statutory care by the Board, although the Board also ran its own homes, such as Fort James in Londonderry, Coneywarren in Co. Tyrone, and Coleshill in Co. Fermanagh.

124 SND 14408.
125 SND 14409.

211 The Board was therefore both purchasing services from Termonbacca and Nazareth House, and in a sense competing with them because it ran its own homes as well. This dual function of the Board generated a perception on the part of the Sisters that the Board would, or might, favour its own homes over the voluntary homes such as Termonbacca and Nazareth House in the allocation of financial resources. This perception, and the financial problems of Termonbacca and Nazareth House, were significant concerns, particularly by the mid-1980s when Termonbacca had closed, Nazareth House was the only voluntary home within the WHSSB area.

212 We accept that the Sisters took significant steps throughout the 1970s to improve the standard of childcare provided at Termonbacca. SND 484 described her first acquaintance with Termonbacca in 1971 when, as a young social worker, she came to place a child in Termonbacca. She felt that it could be a very intimidating environment for a young child, and she considered that it would not be the ideal place to bring a child.[126] Although the children appeared safe and well cared for, she thought that they were probably very institutionalised and would find it difficult to cope in later life.[127] It was apparent to her that there were not that many staff, and that a lot of responsibility rested on one nun who was "like the parent substitute for the whole group."[128] However, by 1978 she considered that the atmosphere was more benevolent than that described by Miss Forrest 25 years before.[129]

213 Whilst she recalled no complaints from individual sisters, or Termonbacca itself, about funding, there were requests from time to time for extra money, for example to fund school trips, no representations were made about staffing. She was unaware that ex-residents were supervising children instead of staff, and that is a further example of how the lack of adequate funding had adverse consequences for the children in Termonbacca.

214 So far as Nazareth House was concerned, when she was in contact with it in the 1980s she considered that the children seemed to be more spontaneous and enjoying themselves more in a better atmosphere, in contrast to her experience at Termonbacca where the children seemed quite subdued.

126 Day 23, p. 13.
127 Day 23, pp. 35 and 36.
128 Day 23, p. 37.
129 Day 23, p. 41.

215 She was impressed by the employment of a residential social worker in 1978, something she regarded as quite enlightened. The employment of SND 332 was as the result of an initiative by SR 2. SND 332 described how SR 2 was very concerned about the need to provide aftercare support for former residents of Termonbacca, and encouraged him to devote a considerable proportion of his working time to ex-residents. Notwithstanding that, we are critical of the amount of time SND 332 did spend with the ex-residents, because that reduced the time he had available to spend with the children, something which we believe should have been regarded as a greater priority. However, the decision to employ a residential social worker was a progressive step, and we mention it at this stage because that appears to have been entirely funded by the Sisters themselves.

216 Another example of the anxiety of the Sisters to provide as high a standard of childcare as they could came in Nazareth House in the 1980s. By this time SR 2 had moved from Termonbacca to take charge of the children in Nazareth House. It was decided that it was necessary to employ waking night staff in all children's homes. Despite the Sisters having no funding to employ such staff, rather than wait until the funding became available SR 2 went ahead and engaged such staff at the expense of the Sisters, although eventually funding was provided by the Board. This is an illustration of the determination of the Sisters at Nazareth House, and SR 2 in particular during her time there, to do as much as they possibly could to obtain adequate financial resources to enable them to provide the highest standard of childcare for their children. HH 5, who was a senior official with the WHSSB said of SR 2 that "she was extremely professional in that she was trying really hard to bring up the standard",[130] and "she was very keen to actually implement any suggestions or any support she was offered and she took advantage of that", and "… [SR 2] [was] making real efforts to try to create a much more family environment for the children."[131] The tenor of the evidence was that she was determined to do the best she could for the children in her care and made many determined efforts to obtain funding for various purposes so that the children placed in care at Nazareth House by the Board would have the same material opportunities as other children looked after by the Board in their own homes.

130 Day 24, p. 111.
131 Day 24, pp. 112 and 113.

217 Although the Board and the DHSS were prepared to provide small amounts of funding from time to time for staff related costs, such as covering staff absences when staff were released for training, the long-term difficulty of insufficient staff remained at Nazareth House until almost the end of the period of our Terms of Reference. A particular problem was that the Sisters were not calculating the charge which they made to the Board for the children in their care on a realistic basis because they were not including in their costings an allowance for the monetary value of the unpaid work they did, nor for the long hours they worked. In order to achieve a realistic figure for the per capita cost of the care of a child it was necessary to allow for the cost of replacing the sisters with paid staff, and because more staff would be required to cover the longer hours which the sisters worked this meant that more staff would be required. Allowance also had to be made for the salary costs of the extra lay workers who might be required to replace the sisters, or whose work the sisters performed. We accept that individual officers of the Board encouraged the Sisters to be realistic in calculating the amount they charged. However, the amount allowed for Nazareth House by the Board on a per capita basis remained a significant problem for a considerable period because it was less than was needed.

218 This became increasingly apparent when Nazareth House applied for capital grants. In May 1983 an application was made for assistance for the cost of replacing windows, and the Board identified that there were 22 children in the home and agreed to contribute 75% of the cost of the work.[132] In 1984, £2,199.38 was paid for this.[133] In 1987 Nazareth House made a further request for financial assistance to help meet the cost of necessary work for fire precautions. The DHSS requested sight of the Nazareth House accounts and a careful assessment of the financial viability of Nazareth House was carried out by the DHSS. The matter was complicated by virtue of the costs of running the old people's home, which were separate from costs relating to the children's home. The DHSS identified that of a total deficit in relation to both homes of £172,075, no less than £114,870 was attributable to deficits in the two preceding financial years on the running of the children's home. The DHSS officer commented:

132 SND 13422.
133 SND 13409.

> "This is a large deficit and could not be sustained by a central body over a long period. It can be seen that the Old People's Home reached a surplus situation in 1985-1986 and Mr. McAteer tells me that this surplus situation is likely to continue. I also understand that an attempt has been made to back-date an increase in the per capita rate for children and this is one of the items being dealt with in a letter dated 22 December 1986 from Mr. Carroll (WHSSB) to our Mr. PJ Armstrong. I have not seen this letter.
>
> In conclusion, the only doubt I have is whether the losses being incurred on the children's home can be sustained over a long period by the sponsoring body in London, thus bringing the viability of the home into question. Provided you are satisfied that the continuation of the children's home is assured, I would agree that Nazareth House is worthy of support on financial grounds at the maximum grant which can be given."[134]

219 The DHSS made a number of payments to pay off the accumulated deficits generated by Nazareth House. In 1987 the Board was allocated £65,000 by the DHSS "to provide additional assistance for voluntary Children's Homes". As Nazareth House was the only voluntary home in the Western Board area, that should all have gone to it, but the Board paid £47,642 to Nazareth House, thereby paying off the 1985-86 deficit only, and paid £8,000 to Rubane in respect of an outstanding bill. The Board was unable to say how the balance was used, although all of the allocation should have gone to Nazareth House.[135] Although substantial deficits were paid off on a number of occasions in succeeding years, by 1995, the end of the period covered by our Terms of Reference, there was still a significant disparity between the cost of running Nazareth House by the Sisters, and the income they were receiving from the State, in the form of payments by the Board made available by the DHSS.

220 In September 1993, £15,230 was sent to Nazareth House,[136] and in December 1993 a further £51,670 was sent. In both instances the money was sent by the Foyle Unit of Management of the WHSSB.[137] It is significant that as late as November 1992 a report from the Social Services Inspectorate[138] commented:

134 SND 13307.
135 SND 13180.
136 SND 8140.
137 SND 8143.
138 SND 9775.

> "Current staffing levels are unacceptably low, particularly when one considers the low level of training within the staff group. As the main purchaser of services the WHSSB, as the corporate parent, is responsible for the standard of care and equity of provision experienced by children in residential care within the voluntary and statutory sectors. There should be comparability of provision across sectors. The current capitation funding for each child prohibits the employment of additional staff and is much below the average costs both within the statutory and voluntary childcare sectors."

221 As TL 19 accepted in his evidence, as early as 1983 funding had been flagged up by inspectors from the SWAG, and yet nine years later the same concerns were being highlighted within the Board.[139] The calculation of per-capita funding is an arcane and complex subject, influenced by the individual services being provided by separate institutions, services which may result in markedly different capitation fees being appropriate. Nevertheless the reality is that throughout the 1970s and 1980s the Western Board was getting services on the cheap from the Sisters of Nazareth, as TL 19 was driven to accept.[140] It is clear that resulted in a "pass the parcel" approach between the Board and the DHSS about how this should be resolved. As TL 19 put it:

> "…the Department were writing to us telling us we needed to look at the level of money being paid to the Sisters of Nazareth, we were writing to them asking them for support to enable us to provide care in some of our facilities to meet the needs of the children."[141]

However, although the DHSS as the ultimate paymaster was well aware of the problem, we consider that it took a remarkably long time for this matter to be addressed. It appears from TL 19's evidence that in 1984 all four health and social services boards began to look at the question of what the capitation fee should be for voluntary residential care in an attempt to reach a level playing field right across Northern Ireland.[142] However, we understand this was not resolved by the end of our period of Terms of Reference, and as late as 1993 when SR 2 was seeking funding to employ three or four extra staff. In June 1993 it was acknowledged in a memorandum from Mr. T. Haverty to TL 19 that

139 Day 24, p. 59.
140 Day 24, p. 63.
141 Day 24, p. 64.
142 Day 24, p. 65.

"As you know I've always been concerned about the staffing levels in Nazareth House."

222 We are satisfied that this concern was not promptly addressed by the Department. Had it done so in a timely and determined fashion it would have resolved the long-running difficulties in a way that would have ensured that Nazareth House was provided with the same level of facilities and staffing that statutory homes received, thereby ensuring that all children in all institutions, whether voluntary or statutory, who were in care across the Province received the same level of childcare. This was not achieved due to the dilatory and indefensible manner in which all those responsible for analysing and dealing with financial help for Nazareth House failed to successfully grapple with the problem. **We regard this as a serious systemic failing on the part of the DHSS whose ultimate responsibility as the provider of funding this was, because when the problem was drawn to their attention they failed to act appropriately and expeditiously to resolve the problem in an appropriate way.**

Further findings of systemic failings by the Sisters of Nazareth; the county and county borough welfare committees, and their statutory successor the Western Health and Social Services Board; the Ministry of Home Affairs; and its successor the Department of Health and Social Services

223 We now set out our findings in relation to a number of systemic failings which we have concluded were made by: the Sisters of Nazareth in respect of both Termonbacca and Nazareth House; by the county and county borough welfare committees; and by the Western Health & Social Services Board, their statutory successor. We also deal with systemic failings by the Ministry of Home Affairs and the Department of Health & Social Services, who were in turn both the ultimate funder and the government department responsible for the statutory inspection and overall oversight of the voluntary homes sector.

224 **For the reasons that we have set out above, we conclude that in addition to those systemic failings we have already identified there were further systemic failings in the following respects.**

(1) The Congregation of the Sisters of Nazareth did not take adequate steps to ensure that they had:

(a) suitable premises, and

(b) sufficient, and

(c) suitably selected and trained sisters and lay staff to prevent abuse of the children in their care, and

(d) an adequate system of internal inspection, and

(e) an effective system of managerial support and supervision.

(2) The Congregation of the Sisters of Nazareth did not take sufficient steps to try to obtain adequate funding for either Termonbacca or Nazareth House.

(3) The Ministry of Home Affairs and the Department of Health & Social Services failed to:

(a) construct, and

(b) implement an appropriately rigorous inspection regime to ensure that the opportunity for abuse of children in St. Joseph's Home, Termonbacca and Nazareth House was minimised.

(4) The Ministry of Home Affairs and the Department of Health & Social Services did not take sufficient steps to ensure that St. Joseph's Home, Termonbacca and Nazareth House were required and/or helped to provide:

(a) suitable premises, and

(b) sufficient, and

(c) suitably selected and properly-trained sisters and lay staff to ensure that the children in these homes would be provided with childcare that was:

(i) in accordance with the standards of the time, and

(ii) of the same standard as that received by children in homes in the statutory sector.

(5) Neither the county and county borough welfare committees (or the Western Health & Social Services Board as their statutory successor) as the statutory bodies which placed, or assumed responsibility for, children in care in St. Joseph's Home, Termonbacca or Nazareth House, took adequate steps to monitor the care given to individual children in either home.

(6) None of the welfare authorities which placed, or assumed responsibility for, children in either home took adequate steps to monitor the facilities for, and standards of care provided to, children in either home.

(7) None of these statutory bodies took adequate steps to inform themselves of the provision made by the Sisters of Nazareth for the care of other children in either home whose circumstances might have brought those children within the responsibility of the statutory bodies concerned.

(8) None of those statutory bodies provided adequate financial or administrative support for the children they placed in the care of the Sisters of Nazareth in either home.

(9) We are satisfied that there was a systemic failing on the part of the Western Health & Social Services Board in approving, and then failing to properly monitor, the highly unusual relationship which SND 38 was permitted to have as both key worker and "befriender" of HIA 127, and in not intervening to manage his continued involvement with HIA 127 after his discharge from Nazareth House.

Contents

Chapter 6:

Module 2 – Child Migrant Programme (Australia)

Introduction

1 This portion of the Inquiry's Report is concerned with its investigations into why and how a number of children from institutions in Northern Ireland were sent to Australia, almost all of whom went in the years after the Second World War. When the Inquiry publicised its existence in Australia in 2013 we received a very large number of applications from people resident in Australia, mostly in Western Australia, and it became obvious that there were two main aspects of their experiences that required investigation: firstly, the allegations of abuse which they say they suffered in residential institutions in Northern Ireland before they went to Australia; and secondly, how and why these children were selected to go to Australia, because many allege that the process was itself abusive. Many are bitterly critical of the institutions for sending them to Australia, and of the Northern Ireland and United Kingdom Governments for permitting and facilitating their being sent to Australia.

2 They also complain of the effect that being sent has had on their lives, not least because they allege they were subjected to serious forms of abuse in the institutions to which they were sent in Australia. In their evidence many described how they lost all contact with their parents and siblings. Although, after many years and much effort, some were able to re-establish some contact with their relatives, for others it was too late, because their parent had died, or, when they were able to trace their parent or family members, the reunions were not successful. Their complaints also extend to other matters, such as not being able to obtain birth certificates, or discovering that their names or dates of birth had been altered, things which created major difficulties for them in later life when they had to prove their identity for official purposes.

3 Many of those who spoke to us in person, or who described their experiences in their written statements, spoke movingly of the profound effect that being sent to Australia as children had upon them. Those who wish to study their accounts in greater detail will find them on the Inquiry website, together with the relevant documents and transcripts, at Days 42 to 50. The words of HIA 324[1] in his statement provide a striking example of the effect upon him of being sent to Australia as a child, views which are representative of the views of many applicants:

> "My life in institutions has had a profound impact on me. I have always wondered what it would be like to have had a family - a mother

1 AUS 10743.

> and father and brothers and sisters. I never got the chance to find out because I was sent to Australia. We were exported to Australia like little baby convicts. It is hard to understand why they did it. I know the theory – to populate Australia. I still cannot get over the fact that I was taken away from a family I never got the chance to know. I was treated like an object, taken from one place to another. I found it very hard to show affection to my children when they were young. I have improved as the years have gone on. I have a nightmare every night of my life. I relive my past and am happy when daylight comes."

HIA 324, who was born in 1938, was 75 when he spoke these words to the Inquiry legal team in Perth in 2013. Sadly he died before he was able to sign his statement and see the Inquiry consider his account, and the accounts of the other child migrants who have contacted us.

It became clear that many questions have been raised by what we have been told:

- Why were child migrants sent to Australia?
- How many were sent?
- Who sent them?
- Who decided that they would go?
- How were they chosen?
- Were their parents consulted?
- What happened before they were sent?
- How did they get to Australia?
- What happened to them when they got there?
- Were they able to contact their parents or families afterwards?

4 In this part of our Report we examine each of these questions except for "What happened to them when they got there?" We take the view that the institutions remained responsible for any child they sent until the child disembarked in Australia, and so we examined the arrangements that were made for the children travelling to Australia, and the conditions during the voyages to Australia. We made clear at the beginning of the public hearings of the module relating to Australia that our powers do not permit us to investigate the experiences of the applicants in the institutions to which they were sent once they arrived

in Australia.[2] However, in order to examine whether the institutions in Northern Ireland took any steps to keep contact with the children, or to inform themselves of the progress of the children, it was necessary for the Inquiry to know what the applicants themselves had to say about these matters. As we explain in the next paragraph, almost every applicant was very concerned about the difficulties they experienced in later life because of the inadequate information available to them about their origins and families in Northern Ireland. In addition, the applicants themselves had much to say about their experiences in Australia. In order to obtain a complete picture of all these matters, when the Inquiry recorded statements from these applicants we therefore included their accounts of the experiences to which they say they were subjected in various Institutions in Australia. After this module we sent their statements to the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) which was carrying on its work in Australia at the same time as our Inquiry carried out our work in Northern Ireland. We did this to ensure that all of these matters were drawn to its attention, because if these allegations are within the Terms of Reference of the Royal Commission it is for the Royal Commission to investigate them.

5 Many applicants who gave evidence to us in this module were unable to remember anything, or if they did they often remembered very little of their time in institutions in Northern Ireland. Where they can recall such matters, their evidence is referred to, where necessary, in those parts of our Report which deal with the particular institutions in Northern Ireland. This portion of our Report is solely concerned with the experiences of those who spoke to the Inquiry in relation to how they came to be selected to be sent to Australia, their experiences on the way to Australia, their experiences after they arrived to maintain contact with their relatives in Ireland during their childhood, or in later years, the success or otherwise of these efforts, and the effects on them of being sent to a different country many thousands of miles away as young children.

6 As part of our investigations we sent members of the Inquiry to Australia for approximately a month at a time in September to October 2013, and June to July 2014. On each occasion the team was made up of two members of the Acknowledgement Forum panel, two members of

2 Chairman's opening remarks. Day 42, 1 September 2014.

our legal team and two witness support officers. They went to Australia for two reasons. Firstly, to enable those applicants now living in Australia to have the same opportunity to describe their experiences to the Acknowledgement Forum as applicants who live in Northern Ireland and elsewhere. Some of the Australian applicants chose only to describe their experiences to the Acknowledgement Forum and did not wish to engage with the Statutory Inquiry element of the Inquiry's proceedings. The second reason was to enable our legal team to record witness statements from applicants in Australia, as well as to gather a considerable amount of documentary material and other information in relation to the matters which the Inquiry will consider later in this part of the Report.

7 Although the majority of the applicants who had been sent to Australia as children landed in, and still live in, Western Australia, some now live in other parts of Australia. In order to enable as many applicants as possible to speak to the Inquiry team at convenient locations, the Inquiry team saw applicants in Perth in Western Australia, in Brisbane in Queensland, and in Melbourne in New South Wales. Many of the applicants travelled considerable distances to speak to the Inquiry team and we are very grateful for them doing so.

8 The Inquiry then devoted nine days of public hearings[3] to examining the experiences of those who were sent to Australia. During that time the Inquiry received oral evidence from eleven applicants. Three who were in Northern Ireland at the time were able to give evidence in person at Banbridge Courthouse, and the other eight did so by live TV-link from Australia. A further 38 witnesses gave their evidence in the form of the written statements which they had provided to the Inquiry; these were read out by Counsel to the Inquiry in public. Altogether we received evidence from 52 of the 65 applicants from Australia, because three further witnesses were not called during the Australian module but gave evidence in a later module in respect of their experiences in institutions in Belfast. Their evidence in relation to those institutions is considered in that part of the report that deals with those Institutions, but their accounts of experiences relating to their migration to Australia are included in this portion of the Inquiry Report. The remainder of the 65 chose not to speak to the Statutory Inquiry, and those who wished to do so spoke only to the Acknowledgment Forum. Sixty-five applicants

3 Days 42 to 50, from Monday 1 September 2014 until Monday 15 September 2014.

represents almost half of all those who we believe were sent to Australia from Northern Ireland as child migrants, and their evidence enabled us to piece together a detailed picture of many of the procedures involved.

9 The Inquiry received many helpful documents from applicants in Australia that greatly assisted us in our work. The Inquiry also carried out exhaustive searches in the Public Record Office of Northern Ireland (PRONI), as well as receiving evidence from the Sisters of Nazareth and the Health and Social Care Board. We also received helpful information from the Child Migrants Trust (CMT) and from Tuart Place in Australia. Documents we obtained from the National Archives of Australia at the end of the module threw considerable light on the arrangements for child migration to Australia between 1938 and 1950, and this file was subsequently added to the evidence bundle.

10 We wish to place on record our thanks to the Royal Commission, which provided staff to accompany applicants at the locations in Australia from which they were speaking to the Inquiry by live link, thereby enabling us to provide the same level and type of support to witnesses giving evidence as we did for witnesses in Northern Ireland. We are also most grateful to the Chief Justice of the Family Court of Western Australia, and to his staff, and to the staff of the Family Court of Australia at Melbourne, for their invaluable help in making available their premises and staff to allow applicants to give evidence by live link.

11 The Inquiry was fortunate in securing evidence from Dr Ann Mary McVeigh, PhD, of the Public Records Office of Northern Ireland (PRONI), and from Dr Margaret Humphreys OBE, OAM. Dr McVeigh made available to us her thesis on the topic '*History of the Child and Juvenile Migration Schemes to Australia*', for which she was awarded a doctorate by The Queens University Belfast in 1995. The greater part of the information contained in this portion of the Report relating to the historical background to child migration to Australia is drawn from Dr McVeigh's work, supplemented by her oral evidence.

12 The topic of child migration to Australia is one that has generated a considerable amount of controversy in both the United Kingdom and in Australia for more than 20 years. It was brought to the attention of the wider public by the work of Dr Margaret Humphreys in particular, and by her book *Empty Cradles: One Woman's Fight to Uncover Britain's Most Shameful Secret*, published in 1994. Not only did this provide

much important background material for the Inquiry, but Dr Humphreys also prepared a detailed witness statement to which we refer later in this Report. In that statement, and in her oral evidence, she described many of the problems faced by former child migrants in re-establishing contact with their families in Northern Ireland and elsewhere, and of the impact of their experiences upon them. These were matters which were also dealt with by applicants in their witness statements. In addition, the Inquiry received a document entitled 'Report on the Impacts and Outcomes of Child Migration Experienced by Former Child Migrants in Northern Ireland', prepared by Dr Philippa White, Director of Tuart Place[4]. The accounts given by many of the witnesses and Dr White's report, taken together with the evidence of Dr Humphreys, provided a great deal of information which we shall consider later. We also received helpful information from Prof. Gordon Lynch, Michael Ramsay Professor of Modern Theology at the University of Kent. Prof. Lynch has made a special study of child migration, and his 2016 book *Remembering Child Migration Faith, Nation-Building and the wounds of Charity*[5] deserves to be read by everyone interested in the history of child migration.

Historical Background

13 The practice of child migration, that is sending young, unaccompanied, minors from the United Kingdom to other countries, is one that has a long history, and antedated the period with which this Inquiry is concerned by over three centuries. In her evidence, Dr McVeigh[6] drew a valuable distinction between what she termed the child and juvenile migration schemes, distinguishing between those who were under fourteen when they were sent, and those over fourteen. At that time, fourteen was an acceptable age to leave school and get work, whereas those who were under fourteen were in the care of an institution or a parent. She found that those over fourteen were mainly people who chose of their own volition to emigrate. Such individuals approached the various organisations and sometimes paid their own fare, or had it paid for them, and went to Australia or elsewhere with the option of going to work. Children under fourteen would have been too young to work and so someone would have made the decision for them to emigrate.

4 AUS 6056-6057.
5 Bloomsbury, 2016.
6 Day 42, page 88.

14 In May 1947 the Australian Assistant Under-Secretary for Lands noted that the "Catholic Episcopal Migration and Welfare Association [in Australia] has asked for 60 boys under 14 years", and that would suggest that a distinction was made at that time between children under and those over fourteen[7] (although some older children did emigrate to Australia under the child migrant schemes). We consider that Dr McVeigh's distinction is a valid one and we have applied it in our consideration to the evidence before us. The overwhelming majority of those who applied to us were fourteen or under when they were sent, and whilst a small number of children were over fourteen at the time they emigrated, in many of those instances we are not concerned with their experiences because they were of a sufficient age to make an informed decision for themselves as to their future, and in almost all cases have not applied to the Inquiry.

15 It is now well recognised that the practice of sending young, unaccompanied, minors abroad has a long and varied history, indeed the first contingent of young migrants was sent to Virginia in 1619. Throughout the remainder of the 17th century, and during the 18th and 19th centuries, child migration to various colonies and dominions within the British Empire and Commonwealth was widespread. Although various acts of the United Kingdom Parliament were passed which permitted this policy, the actual migration was arranged by statutory, voluntary or religious organisations, which made all the necessary arrangements. In later years subsidies of various sorts were paid to these organisations both by the British Government and by the authorities in the countries to which the children were sent.

16 Throughout the 19th century large numbers of young children were assisted to emigrate, mostly to Canada. Canada remained the favourite destination for child migrants for many years, although critical reports of the experiences of children sent to Canada led to the practice being brought to an end by the Canadian Government in the 1920s.[8] Despite many contemporary reports which revealed serious shortcomings and abuses in the practice of child migration to Canada,[9] there still remained a considerable body of opinion in the United Kingdom that

7 NAA A445, 133/2/9, dated 23 May, 1947.
8 See Roy Parker, *Uprooted: the shipment of poor children to Canada, 1867-1917* (Bristol, 2010), for a history of child migration to Canada.
9 Such as a report by Andrew Boyle to the Local Government Board in 1874 described in Parker, Uprooted, pp 49-55.

was strongly supportive of the principle of child migration. Therefore, despite child migration to Canada becoming less popular, in the 20th century Australia became a more popular destination for child migrants, although some children did go to other countries such as New Zealand, South Africa and Southern Rhodesia (now Zimbabwe). It is noteworthy that whilst in general the Canadian authorities wanted older children who could work, the Australian authorities, as we shall see, and the Roman Catholic Church in Australia, wanted younger children who could then be moulded into Australian citizens.

17 In the early part of the 20th century a number of schemes for child migration were created by voluntary societies which flourished at the time. The Big Brother Movement was launched in London in July 1925, and the first consignment of 'Little Brothers' arrived in Australia in 1927. The Big Brother Movement was essentially an assisted passage scheme for boys aged sixteen to seventeen and a half. It guaranteed to find employment and accommodation for each young man, and to be his legal guardian until the age of 21. It provided a surrogate 'Big Brother' who would keep a fraternal eye on the youngster. Between 1925 and 1931, it introduced 1,926 boys into Australia, until its activities were halted by the Depression. It re-established itself in the late 1930s but its efforts were interrupted by the onset of the Second World War. It again re-established itself after the war and sent an average of 200 boys a year from 1947 until the 1970s.

18 The Fairbridge Society was named in honour of its founder Kingsley Fairbridge. It sent children to be brought up in farm schools where they would be taught to be farmers and farmers' wives. Kingsley Fairbridge bought a small farm near Perth, Western Australia, and the first party of boys arrived in January 1913. Throughout the 1920s and 1930s the farm school continued to grow and a second farm school was opened in New South Wales. By the outbreak of the Second World War, the Society had sent 1,202 children to Australia. When migration resumed in 1947, approximately 600 more unaccompanied child migrants passed through Fairbridge. The Society was a non-denominational organisation, and such was its reputation that many other organisations, including local authorities, church-based associations, and various children's societies sent children in their care to be brought up on Fairbridge farms in Australia.

19 One of these societies was Dr Barnardo's. In due course it opened several more homes and training schools in Australia, and by 1960 there were nine Barnardo's centres in Australia, all in New South Wales. From 1921 approximately 3,000 children emigrated to Australia under Dr Barnardo's auspices, 500 of whom left Britain after 1947. Barnardo's sent the last group of migrant children to be sent to Australia, a party of nine, in 1967. Seven children who were born in Northern Ireland emigrated to Australia from Barnardo's homes.

20 As we describe later, the Roman Catholic Church was also closely involved in arranging for child migrants to go to Australia, mostly after the Second World War.

Legislation

21 In the 19th and early 20th centuries a number of acts were passed by the United Kingdom Parliament which made provision for the emigration of children. Section 70 of the Children Act, 1908[10] provided for the apprenticeship or disposal by emigration of any youthful offender, or child detained or out on licence from a certified school, by the managers of the school, as if they were the parents of the child (provided that the consent of the Secretary of State was given), where the disposal was to be by way of emigration. After a separate Government came into existence in Northern Ireland in 1921 this power was availed of on a number of occasions by the Ministry of Home Affairs in Northern Ireland.

22 The principal legislative provision with which the Inquiry has been concerned was the Empire Settlement Act of 1922, which was replaced by the Empire Settlement Act of 1937, which in turn was succeeded by the Commonwealth Settlement Acts of 1952, 1962, 1967, and these three acts are properly cited as the Commonwealth Settlement Acts 1922 to 1967. Section one (1) of the 1922 Act stated that:

> "It shall be lawful for the Secretary of State, in association with the government of His Majesty's Dominions, or with public authorities or public or private organisations either in the United Kingdom or in any part of such Dominions, to formulate and co-operate in carrying out agreed schemes for affording joint assistance to suitable persons in the United Kingdom who intend to settle in any part of His Majesty's Overseas Dominions."

10 document, HIA 118.

23 The Act and its successors did not specifically empower voluntary organisations, or anyone else, to send children in their care abroad. However, if the Secretary of State agreed that a child migration scheme, whether set up by a voluntary organisation or any other body, fell within the terms of the Act, public funding could be provided to subsidise the cost of the scheme. The 1922 Act was time-limited, and the scheme was therefore extended by the Acts of 1937, 1952, 1962 and 1967 until it lapsed on 31 May 1972.

24 Other statutes gave the Secretary of State, or other responsible Minister, power to consent to the emigration of an orphan or deserted child where certain formalities were complied with. In the rest of the United Kingdom the relevant legislation was section 84(5) of the Children and Young Persons Act 1933 which gave the Secretary of State power to authorise arrangements for the emigration of any child in the care of a fit person, if it appeared to him that it would be for the benefit of the child. The Secretary of State had to consent to the emigration, and was required to be satisfied that the child consented, and that his parents had been consulted, or that it was not practicable for the parents to be consulted. The Act also provided (paragraph 7, schedule 4) that managers of an approved school had the power to arrange for the emigration of a child in their care with the written consent of both the child and the Secretary of State.

25 Prior to the enactment of the Children and Young Persons Act (Northern Ireland) 1950 (the 1950 Act), the relevant statutory provisions that operated in Northern Ireland after 1921 were sections 21 (6) and 70 of the Children Act 1908. Section 111 (5) of the 1950 Act contained a similar provision to the 1933 statute for those children committed to the care of a fit person. A fit person could be either an individual or a voluntary home, as was the case in respect of those children from Barnardo's where consent was sought from the Ministry of Home Affairs in relation to children committed to its care before the children were sent abroad.

26 Schedule 4, paragraph 7, of the 1950 Act empowered the managers of a training school to arrange the emigration of a child in its care, with his written consent and that of the Ministry. In Northern Ireland it was the consent of the Minister of Home Affairs that was required, not that of the Secretary of State, although, as we shall see, little use was made of this provision in Northern Ireland.

The rationale behind child migrant schemes

27 The arguments of those who supported such schemes embraced both concern for the child, and concern for country or community. A very important consideration for many societies of all religious denominations was the religious and moral welfare of the young person. There was a desire to safeguard the child's religious and moral well-being, by removing the child from the danger to which it was felt that child could be exposed if it were to remain either in its own, unsatisfactory, home or in an institution. There was also a belief that the British Isles were over-populated, whereas the colonies were under-populated. A similar, but separate, argument was that there was a need to build up and maintain the Empire, and to ensure that the predominant population of the Empire was of white, British stock.

28 The most enduring argument in favour of such schemes was a financial one. Those youngsters who were selected and sent to the colonies would have a chance to "better themselves", and, by their removal, more room would be made available in over-crowded workhouses, orphanages and homes for other children in need of care. The fare to Australia would therefore be money well spent. All the major child and juvenile migration agencies used some variant of this economic argument. At its simplest, it was reckoned that it was cheaper to send a youngster abroad than to keep it for several years in a workhouse. In later years, this argument was refined, by providing emphasis on the benefits to the child and to the colonies of child migration. The child or youth who was otherwise un-provided for should be sent to the colonies where he or she could find farm or domestic work, thereby relieving unemployment at home, whilst increasing the labour force of the receiving country.

29 As was the case with child migration to Canada, a further consideration was the belief that sending children to a healthy outdoor life in the fresh air and sunshine of Australia, far away from the slums, from evil influences and from institutional life, would do more for a poor child than all the charity offered at home. This view was expressed by Arthur Lawley in his epilogue to *The Autobiography of Kinsgley Fairbridge* in 1934 when he said that children could become "strong, sturdy and efficient citizens able to play their part in developing the vast resources of Australia."[11]

11 Arthur Lawley, in the epilogue to The Autobiography of Kingsley Fairbridge (London, 1934), p.179.

30 Some people considered the risk of drifting into the "wrong" religion even more damaging. Most religious denominations had their own homes, each replicating the work of homes of other religious denominations. Each jealously guarded its own sphere, and great emphasis was placed by many denominations on the need for children who migrated to be brought up in what was regarded as the "correct" religion. As we shall see, the Roman Catholic Church was also influenced by the desire to increase the number of Roman Catholics in Australia.

31 In the 1920s the Australian Commonwealth (i.e. central) Government and state governments offered grants to support assisted passages, but by 1930, as the Australian Year Book of 1932[12] makes clear, those concessions were limited to: "boys for farm work, young women for household employment, and to nominees, mainly wives and children of husbands in Australia." These concessions were revoked in 1932, and although assisted migration resumed in 1938, it was curtailed due to the approaching hostilities, and assisted passages were not reintroduced until 1947.

Attitude of the Australian Government post 1945

32 The Australian Senate Report makes clear[13] that the Commonwealth Government had been developing plans to bring large numbers of child migrants to Australia before the end of the Second World War. On 2 August 1945, the Minister for Immigration referred to the Government's plan to bring 50,000 orphans to Australia during the first three years of peace. The Minister, the Hon Arthur Calwell, said:

> "Pending the resumption of large-scale adult migration, the Government will take every available opportunity to facilitate the entry into Australia of accepted children from other countries. The Government has already approved in principle a plan to bring to Australia, in the first three years after the war, 50,000 orphans from Britain and other countries that had been devastated by the war. Discussions on the details of this plan are proceeding with the States, and we hope soon to reach a stage where the full possibilities of the scheme can be properly assessed."[14]

12 An Australian Government publication.
13 *Senate Report*, paragraphs 2.60-2.65.
14 Ibid, paragraph 2.61, quoting House of Representatives, Debates, 2 August 1945, p.4914.

33 When it became clear that the target of 50,000 war orphans could not be reached, not least because there were not as many true orphans as had been anticipated in Britain and in other European countries, it was decided that as far as possible the Commonwealth Government would rely on private organisations such as Barnardo's, Fairbridge, and the religious organisations to promote child migration. Neither private fostering nor adoption of child migrants was favoured, partly for legal reasons as the death of the parents of refugee children might be impossible to determine.[15] As had been the position before the war, it was agreed that maintenance payments for children would be shared between the British, Commonwealth and state governments.[16] Some figures illustrate the type of payments that were made. In Western Australia the payments for child migrants up to 16 years were:

1948

Commonwealth child endowment	10s per week
State subsidy	3s-6d per week
British Government subsidy	6s-3d per week
Lotteries Commission	3s per week
Total	£1-2s-9d

1963

Commonwealth child endowment	10s per week
State subsidy	15s per week
British Government subsidy	£1-5s per week
Lotteries Commission	10s per week
Total	£3-0s-0d.[17]

In succeeding years considerable differences developed in the amounts allowed by individual states and these are described in greater details in the Australian Senate Report.

Concerns about Child Migration

34 Child migration had been the subject of expressions of concern, both about the rationale for the schemes, and about their operation, prior to the Second World War, particularly as the reports we have referred to above

15 Ibid, paragraph 2.63.
16 Ibid, paragraph 2.77 to 2.88.
17 These amounts are in the pre Australian Dollar currency of pounds, shillings and pence.

began to surface showing the unsatisfactory conditions experienced by children sent to Canada. At the end of the Second World War the British Government set up a committee chaired by Miss Myra Curtis CBE, which reported in 1946. The *Report of the Care Children Committee* (the Curtis Committee) considered the various options available for care of children in need in Britain. Although primarily concerned with the British childcare system, the Curtis Committee did consider the matter of child migration. Given the many difficulties and experiences experienced by the witnesses to this Inquiry, the following passage from the Curtis Committee report is particularly noteworthy:

> "We understand that organisations for sending deprived children to the Dominions may resume their work in the near future. We have heard evidence as to the arrangements for selecting children for migration, and it is clear to us that their effect is that this opportunity is given only to children of fine physique and good mental equipment. These are precisely the children for whom satisfactory openings could be found in this country, and in present day conditions this particular method of providing for the deprived child is not one that we especially wish to see extended. On the other hand, a fresh start in a new country may, for children with an unfortunate background, be the foundation of a happy life, and the opportunity should therefore in our view remain open to suitable children who express a desire for it. We should however, strongly deprecate their setting out in life under less thorough care and supervision than they would have at home, and we recommend that it should be a condition of consenting to the emigration of deprived children that the arrangements made by the Government of the receiving country for their welfare and aftercare should be comparable to those we have proposed in this report for deprived children remaining in this country."[18]

The report further stipulated:

> "The emigration of deprived children should be subject to the condition that the receiving Government makes arrangements for their welfare and supervision comparable to those recommended in this report."[19]

18 Page 193.
19 Page 182.

35 The qualified approval for the principle of child migration, and the note of caution, expressed by the Curtis Committee was not the only expression of concern about the propriety and effectiveness of child migration to Australia at this time. The president, chair and secretary of the British Federation of Social Workers wrote to *The Times* on 24 March 1948 raising concerns about the system.[20] The British Federation of Social Workers attempted to obtain changes to the bill then going through Parliament which ultimately became the Children Act 1948, but were unsuccessful. The National Council of Social Services also published a critical report in relation to child migration in 1951.

36 In view of these concerns we consider that it can fairly be said that although after the Second World War the principle of child migration continued to receive support from governments, and from secular and religious groups, it behoved all those concerned with child migration to look very closely at what was being done in order to prevent well-known difficulties and problems happening again.

The Role of the United Kingdom Government

37 On 24 April 1939, the Secretary of State for Dominion Affairs on behalf of the United Kingdom Government signed an agreement with the Christian Brothers of Western Australia under the Empire Settlements 1922 and 1937. This agreement, which was stated to be made with the approval of the Commonwealth and Western Australian governments, provided that the UK Government would provide money to the Christian Brothers towards the cost of extending the Christian Brothers' Agricultural Training Farm at Tardun, and contribute towards the maintenance of up to 50 British migrant children at Tardun. The agreement, which was not to extend after 31 May 1952, contained provisions regarding the type of education and training the children would receive at Tardun.[21]

38 Because of the outbreak of the Second World War it was not until after the end of the War that child migration resumed. It is clear from the documents the Inquiry has obtained from the National Archives of Australia that the involvement of the United Kingdom Government was not confined to providing the legislative framework that allowed organisations to arrange child migration to Australia, nor (as we shall see

20 Gordon Lynch, Remembering Child Migration, p.63.
21 NAA, A445, 133/2/8.

later) to making a financial contribution towards the operation of such schemes, because it would only allow children to be sent to Australian institutions that were approved by it. Inspections of institutions were carried out by British government officials, and in one case the findings about the Christian Brothers' institution at Clontarf were so critical that Clontarf was removed from the list of approved institutions, and the numbers that could be sent to Tardun and Bindoon were reduced, until the United Kingdom Government was satisfied that the necessary improvements had been made.[22] Detailed examinations of these institutions were then carried out by the Australian authorities.

39 In 1953 John Moss, about whom we shall say more later, made use of a visit to Australia to carry out a fact-finding mission on behalf of the United Kingdom Government. He and his wife visited many of the institutions to which children were sent. Although his report was critical of some aspects of these institutions, he nevertheless supported the principle of child migration. In 1956, a further fact-finding mission was sent to Australia by the United Kingdom Government. This was chaired by John Ross, who expressly criticised five institutions. Ross attached a secret annex to his report that was not published at the time. In that annex he was very critical of a number of other institutions that he had not publicly criticised, because he had not been to all of them, and the information was not sufficiently strong in some instances to allow him to express public criticism.

40 The Australian Commonwealth and state governments took time to respond to these criticisms and as both reports became available, the two reports, and the responses to them, were furnished to the Northern Ireland Government by the United Kingdom Government. However, although the Australian response was prepared on 16 January 1957, the last group of children sent from Northern Ireland by the Sisters of Nazareth embarked for their voyage to Australia on 24 December 1956. Apart from a small number of older children who were sent to Australia in 1969, the children who embarked on 24 December 1956 effectively represented the end of child migration from Northern Ireland to Australia so far as this Inquiry is concerned.

22 NAA, A445, 133/2/8, letters 9 June 1947 Garnett to Wheeler, and cablegrams 30 April and 10 June 1947.

41 For whatever reason, the numbers of children going from the United Kingdom as a whole to Australia declined significantly during the 1950s. In a debate on 9 February 1959 the Under-Secretary of State for Commonwealth Relations (C.J.M. Alport) told the House of Commons that whereas 388 children had emigrated in 1950, in 1958 only 80 had done so. At the end of November 1958 out of nearly 2,000 places available to the United Kingdom, over one half were unfilled, and only 62 children were awaiting transport to Australia.[23] The numbers going to Australia from the United Kingdom as a whole continued to decline very significantly, and by the end of the 1970s child emigration to Australia had virtually dried up.

The Position of the Northern Ireland Government from 1921 Onwards

42 We have not directed our attention to any of those who were sent from Northern Ireland prior to the outbreak of the Second World War because none of those individuals applied to the Inquiry, and in some instances at least the children concerned were over the age of 14. In the pre-Second World War period the Northern Ireland Ministry of Home Affairs policy in relation to child migration by children from training schools can be seen from the following passage from a letter of 4 May 1928[24] by the Assistant Secretary responsible, who wrote to the clerk of each county borough council and each county council:

> "...in the majority of cases the disposal of a child by emigration will effect a substantial saving in the sum which would otherwise be expended in capitation grants by the Government and the local authority if the child were to complete its full term at the School. But apart from such financial considerations the Ministry considers it desirable in the interests of the children that when a suitable opportunity for emigration presents itself this should not be lost by reason of lack of funds. It will be realised that owing to the present prevalence of unemployment in this country it is difficult to ensure a means of livelihood for young persons on discharge from Certified Schools and it sometimes happens that in such cases young persons after discharge from the School drift back to a life of crime a result which might have been avoided had they been enabled to obtain work in the colonies."

23 Hansard (House of Commons Debates), 9 February 1959, pp 9 and 10.
24 AUS 4421.

43 It is significant that in the response of 31 May 1928 from the Children Act Committee of the County Borough of Belfast (Belfast Corporation) a pertinent point was made about the age of children who should be considered for emigration from Industrial Schools when the Town Clerk stated that:

> "...in their opinion it would not be desirable except in very exceptional circumstances, when a child was being emigrated in the care of near relatives, that children under 16 years of age should be emigrated. They quite agree with you, however, that the important consideration in the matter is the welfare of the child."[25]

44 After the Second World War the role of the Northern Ireland Government and the Ministry of Home Affairs was largely confined to the Minister considering whether to approve the emigration of children who were in care, either because they were in a training school or other penal institution, or because they were in local authority care. As we shall see, the number of such children was small. Whilst ministerial consent was not required for the migration of children who had been placed voluntarily in homes of whatever denomination or from secular homes, because these children were not covered by the legislative provisions, nevertheless the Government was well aware of the considerably larger numbers that were likely to be sent to Australia under the child migration schemes that were supported by various Roman Catholic organisations. It is convenient to consider the position of the Northern Ireland Government in relation to two distinct categories of children: the first being those children who were in the care of statutory organisations, such as county welfare committees or training schools; the second being those children who were in voluntary care.

45 Different considerations of both law and practice applied to each category. With the enactment of the Children and Young Persons Act (Northern Ireland) 1950 (the 1950 Act) provision was made for the emigration of three categories of children, each category requiring the consent of either the Minister, or the Ministry of Home Affairs.

(1) Under section 94 (1) and (2) of the 1950 Act, welfare authorities were given power to arrange for the emigration of children in their care, but this was subject to the consent of the Ministry.

25 AUS 4028.

(2) Section 111 (5) of the 1950 Act gave the Minister power to consent to the proposed emigration of a child who had been "committed to the care of a fit person", subject to the Minister being satisfied as to certain matters. This applied to those who had been placed in care by a court, or who had been formally taken into care by a welfare authority.

(3) The managers of training schools were empowered to arrange for the emigration of a child, provided (a) that the child gave written consent, (b) the Minister also gave his consent, and (c) before exercising their powers "the managers shall, where it is practicable to do so consult with the parents of the person concerned."

46 Thus, in May 1950, the St. Patrick's Boys School run by the De La Salle Order put forward several boys as candidates for emigration to Australia, all but three of whom had already completed their period of supervision in the training school. Therefore only the three candidates still under detention required Ministerial consent by virtue of paragraph 7 of schedule 4 of the 1950 Act. Two of the three boys were aged sixteen and nine months, and the third was aged eighteen and five months. Ultimately the Minister gave his consent and all three boys emigrated.[26]

47 It is unclear how many boys ultimately went to either Canada or Australia by virtue of the provisions which governed emigration from training schools, but all the boys sent before and after the Second World War were close to adulthood at the time. Although all of these children fall within the ambit of the Inquiry, so far as the Inquiry has been able to ascertain all were in the fifteen to eighteen year old age bracket, and we consider that they were therefore of an age when they could make an informed choice as to whether they wished to go to Australia. Indeed several of those in this category seemed to have taken the initiative to do so. None have approached the Inquiry, and because of that, and their age when they emigrated, we have not considered the circumstances surrounding their emigration any further.

48 We know that in November 1950, ten children sailed on the same vessel, all of whom came from either county welfare committee care, or from the Protestant run home at Manor House, Lisburn, Co Antrim. Despite intensive efforts by the Inquiry we have obtained little information about many of those children who went from local authority homes,

26 See AUS 5923, letter dated 16 June 1950.

but we are aware from a passenger list that two children, AU 110 and AU 111, sailed in November 1950 with several other children, some of whom are applicants to the Inquiry. The passenger list suggests that these children were sent to Australia by the County Londonderry County Welfare Committee, but the HSCB has been unable to find any documents relating to either person.[27]

49 Of those who have been identified by the Inquiry's researchers, or of whom we have been told, the position appears to be as follows:

(1) Three children (including AU 110 and AU 111) were sent for emigration by various county welfare committees in November 1950.

(2) In 1952, three brothers were put forward for emigration to Australia by County Armagh Welfare Committee. Although the records do not expressly state that they were sent to Dhurringle, this appears highly probable because there is a reference to them being sent to a Church of Scotland (i.e. Presbyterian) Foundation. It is noted that they sailed on 11 June 1952, and their arrival in Australia was reported on 28 November 1952. Whilst the ages of the three brothers are not stated, it appears probable that two of them were no longer of school age because they were described as working. Whilst the age of the third brother is not stated, because no reference is made in the records to his working or being available for work, it may be inferred that he was still of school age, in other words under fourteen.

(3) The South Eastern Health and Social Care Trust has found evidence that suggests that two brothers (aged sixteen and four months and fifteen and one month respectively), were discharged from Marmion Childrens Home to Australia on 24 February 1954.

(4) A third boy was discharged from the same home to Australia on 14 April 1957, although no further information is available.

50 A number of other children in the care of county welfare committees were put forward for, and it appears were ultimately given approval for, emigration.

(1) In 1951 or 1952 a child who appears to have been fifteen or sixteen, and to have been boarded out (i.e. fostered) by Antrim County Council was accepted by the Big Brother Movement.[28]

27 AUS 5993, Statement of Fionnula McAndrew.
28 AUS 5167.

(2) In November 1956 County Down County Council noted on 30 November 1956 that a boy was at Dhurringle, although no further record in relation to his emigration has been found.[29]

(3) In 1965 two boys were apparently given permission, and financially assisted, in their emigration to Australia.[30]

(4) Finally, in April 1964 Belfast County Borough Welfare Committee sought authority for a boy of unspecified age to travel to Australia under the auspices of the Big Brother Movement so that he could join his foster parents. It appears that he did not emigrate, because he was turned down by the Australian Chief Migration Officer in July 1964.[31]

Therefore, of some fourteen children who appear to have been sent to various institutions in Australia from County Welfare Committee Homes, four were in the fifteen to eighteen year bracket and so we have not considered them further.

51 Of the remaining ten, we have been able to discover nothing other than the barest details, except for HIA 354. His case is of particular importance because, uniquely so far as we can discover, in his case voluminous records have survived which enabled the Inquiry to establish with very considerable precision all, or virtually all, of the relevant circumstances surrounding his migration. These include what steps were taken, and by whom, at almost every stage of his migration at the age of eight years and four months until he was twenty one. As a result, much light has been thrown on the procedures of the County Tyrone Welfare Committee, the Ministry of Home Affairs, and the Australian immigration authorities. His case also provides an example of what could have been done by other institutions that sent children to Australia, such as Manor House, Lisburn, and the Sisters of Nazareth. For this reason we have examined the circumstances relating to the emigration of HIA 354 in detail.

52 Before doing so, it is appropriate to examine the attitude of the Northern Ireland Ministry of Home Affairs towards those children who were sent to Australia but who were privately placed in care, such as those from Manor House and the four Sisters of Nazareth homes in Northern Ireland. It appears the Northern Ireland Government chose

29 AUS 5006.
30 AUS 4349.
31 AUS 4349 and 4350.

not to include provisions in the 1950 Act which corresponded to those of the Children Act, 1948 (a Westminster statute which did not extend to Northern Ireland), and which would have enabled the Ministry to control any activities of voluntary organisations in connection with the emigration of children. The reason was that the Second Parliamentary Draftsman informed the Ministry of Home Affairs that the question of including similar provisions in the 1950 Act had been considered when the Bill was being drafted, and the view was taken that the control of emigration was a matter for the United Kingdom Government and that the Stormont Parliament had no power to legislate in the matter. We accept that the position at that time was that the Ministry of Home Affairs did not have any legal responsibility for the emigration of children who were in voluntary homes because those matters were legally the sole responsibility of the United Kingdom Government. There was therefore no legal duty on the Ministry of Home Affairs to inform itself about arrangements being made by voluntary organisations for the migration of children in their homes. Nor was there a legal duty on those voluntary organisations to inform the Ministry of any arrangements the organisation was making for the migration of children in its care.

53 However, even if such powers had been taken they may not have been exercised, because the Westminster Government did not make any regulations of that type under the legislation corresponding to the 1948 Act until 1982, when the Emigration of Children (Arrangements by Voluntary Organisations) Regulations, 1982[32] were made under section 62 (1), (2), and (3) of the Child Care Act 1980. Given that the United Kingdom Government did not consider it necessary to make regulations to enable it to control the arrangements for emigration by voluntary organisations for many years after the events with which this Inquiry is concerned, and as it was the almost invariable practice of the Northern Ireland Government to follow as closely as possible in every respect corresponding legislative and procedural processes being followed in England and Wales, it may well be that the Northern Ireland Government would never have utilised any such powers even if, contrary to the advice it had been given, it had enacted such provisions in the 1950 Act.

54 Nevertheless, despite the legal position, the Ministry of Home Affairs was well aware from several sources that the Sisters of Nazareth were sending children to Australia. First of all, the Roman Catholic body

32 SI 1982/13.

that was closely involved in arranging for children from Roman Catholic homes in Northern Ireland provided a great deal of information to the Ministry of Home Affairs when the secretary of the Australian Catholic Immigration Committee (ACIC) wrote to the Ministry in August 1949.[33] In the letter it was explained that whilst the Scottish Secretary of State would not normally consent unless the child was over ten, there were many children in Catholic homes in Northern Ireland whom the ACIC "would willingly place in the Australian homes", saying that Termonbacca "would like us to take about eighteen boys whose ages vary from two years to twelve." The writer commented that as all these children were privately placed she thought they would probably be available to go. She also said that other children from other homes might be sent in the future.

55 Enclosed with the letter was a copy of the ACIC's quarterly progress report relating to Scotland and Northern Ireland. This was a very detailed document,[34] and included information about the numbers of children sent from Roman Catholic homes in Scotland and Northern Ireland. It stated that by 1949, 63 children emigrated from Northern Ireland, thirteen of whom came from Nazareth House in Londonderry, 27 from Termonbacca, and 23 from Nazareth Lodge in Belfast. The Ministry of Home Affairs was therefore fully informed about several crucial matters: namely the number of children being sent from the Sisters of Nazareth homes in Northern Ireland; that some of the children were as young as two; and that the Scottish authorities would not normally agree to children younger than ten being sent.

56 In 1949 the views of the Northern Ireland Government were also sought by the Westminster Government about a query raised by the Australian Commonwealth Government concerning the provisions made in Australia for the guardianship of the children who were sent from the United Kingdom, and the meaning of the term '"guardian" in section 17 of the Children Act, 1948[35], one of the matters also raised in the letter from the secretary of the ACIC. The Ministry of Home Affairs decided they would apply the broader definition of "guardian" applied in England and Wales and not the limited Scottish view, as can be seen from a letter of 13 February 1950[36] in which it said that:

33 AUS 4074-4075.
34 AUS 4078 to 4079.
35 AUS 4081-4083.
36 AUS 4089.

> "Our Children and Young Persons Bill will enable a Welfare Authority to procure, or assist in procuring, the emigration of any child in their care, but where the child is capable of giving his consent such consent will be necessary. Where the child is too young to form an opinion he must emigrate in company with a parent, guardian, or relative, or must be emigrating to join a parent, guardian, relative or friend. In all cases the parent's consent must, where practicable, be obtained and the Ministry's approval will also be necessary in each case. As regards children in training schools, the Managers may, with the child's consent and with the consent of the Ministry, arrange for his emigration, and must, where possible, consult with the child's parents."

The Ministry felt that should a limited definition of 'guardian' be applied then, as feared by the High Commissioner in Canberra:

> "...the consequences will be a virtual cessation of the migration to Australia, under the auspices of and for placement with voluntary child migration organisations approved by our respective governments, or children maintained whether wholly or partially by Local Authorities responsible to the Scottish Home Department."[37]

57 These communications from the Home Office and the ACIC were not the only sources of information available to the Ministry of Home Affairs about the scale of child migration connected with the Sisters of Nazareth. On 21 November 1955 Miss Forrest (one of the Ministry's inspectors of voluntary children's homes) reported on a visit to Nazareth Lodge, Belfast in which she referred to being told by the Mother Superior that the home was about to send 23 children to Australia, and possibly another 20. In the event, it seems that no children were sent from Nazareth Lodge in 1955, because the information provided to the Inquiry by the Sisters of Nazareth (and we will comment upon the reliability of that evidence later) suggests that the next group of children who went after November 1955 consisted of one boy from Nazareth Lodge who went on 21 September 1956, followed by thirteen who went on 24 December 1956. It would seem that, for whatever reason, Nazareth Lodge did not send as many children as it had contemplated in November 1955.

58 The significance of the cumulative effect of these sources of information is that they show that for several years the Ministry of Home Affairs was

37 AUS 4082.

well aware that significant numbers of young children were being sent to Australia by the Sisters of Nazareth in Northern Ireland. There was also considerable information in the public domain to suggest that very young children were being sent, because it was well publicised at the time that children were being sent from Northern Ireland to Australia. For example, a picture in the *Derry Journal* of 2 August 1947 shows a group of boys from Termonbacca ready to leave for Australia. When they arrived in Australia considerable publicity was given to their arrival, which was recorded on newsreel films and in Australian newspapers. The practice of child migration from Northern Ireland was therefore widely known, and, so far as the Inquiry is aware, did not result in any adverse comment in Northern Ireland at the time.

59 The Inquiry has found no evidence to show that the Ministry was aware that children had been sent from non-Roman Catholic homes, such as Manor House, Lisburn.

60 Given that the Ministry was alerted to the practice of voluntary homes run by the Sisters of Nazareth in Northern Ireland sending children to Australia on a significant scale over a number of years, ought it to have made efforts to find out more information about those being sent, such as their ages? After all, the Minister had been advised that his consent should be refused when it was required in respect of children who were in care and who were under twelve years of age, and in the light of the information they had, should the Minister and the Ministry not have taken steps to inform themselves more fully of the circumstances of children being sent by voluntary institutions, even though the Minister had no responsibility for those institutions, in order to see whether the standards being applied to the emigration of children by those institutions were no less stringent than those he applied to the children in care who were his responsibility? Was it sufficient for the Northern Ireland Government to leave the matter purely in the hands of the United Kingdom Government? After all, a memorandum of 2 January 1950 pointed out that the scheme was "being worked mainly through the Roman Catholic voluntary homes here in Northern Ireland", and after referring to the decision not to seek power to control child migration by voluntary organisations, the writer observed "the whole question is more likely to arise in connection with voluntary organisations than in relation to children in the care of Welfare Authorities."[38]

38 AUS 4086.

61 In her oral evidence on Day 223 on behalf of the Department of Health (the successor of the DHSSPS by this time), Dr Harrison explained that the concessions made by the Department had been agreed by the First Minister and deputy First Minister on behalf of the Executive. Dr Harrison dealt with this issue at 7.12:

> "The migration of children was an initiative of the UK Government and there was no evidence to suggest that MoHA or the Executive Committee of the Privy Council (the Northern Ireland governing body) were involved in the establishment of such schemes. Nevertheless MoHA and members of the Northern Ireland Cabinet were aware of their existence and operation in Northern Ireland. The Department has already conceded that the migration of children was a misguided policy. The Department has stated to the HIAI that it fully endorsed the Prime Minister's apology and acknowledgments in this matter."[39]

62 We consider that the Department's acceptance that the child migration policy was misguided, and the endorsement of the Prime Minister's apology and acknowledgements do not constitute a clear admission by the Department that there was a systemic failing by the Northern Ireland government of the time in its attitude to child migration. We are satisfied that the Ministry of Home Affairs was content to leave matters in the hands of both the United Kingdom Government and Roman Catholic organisations, and was indifferent to what the Roman Catholic or other voluntary organisations were doing. Although, as we have said earlier, the Northern Ireland Government did not have a responsibility towards those children who were in voluntary care, whether the children were in the care of statutory bodies or voluntary organisations they were Northern Ireland children, and it is our firm view that the Northern Ireland Government was therefore under a moral responsibility to ensure that such children were treated by voluntary organisations in the same way as those children for whom it had statutory responsibility. We consider that this indifference was unjustified, and that the Northern Ireland Government ought to have taken steps to fully inform itself as to what was happening once it became aware that significant numbers of such young children were being sent to Australia by voluntary organisations such as the Sisters of Nazareth. **We regard its failure to do so as a systemic failing on its part.**

39 GOV 785.

63 Although primary responsibility for sending children in voluntary care to Australia must rest with the Australian and United Kingdom Governments for encouraging, permitting and facilitating this, with the voluntary organisations concerned that sent the children, and with the Australian organisations that encouraged Northern Ireland organisations to send children to them, the Northern Ireland Government cannot escape a degree of responsibility for what happened, because there is no evidence to suggest that the Northern Ireland Government took any steps to satisfy itself that the children it had approved for child migration were being properly looked after in Australia, let alone that it concerned itself with the children sent by the Sisters of Nazareth.

64 The attitude of the Northern Ireland Government is in contrast to the actions of the Scottish Home Department and the United Kingdom Government. In 1950 the Scottish authorities sent Miss H.R. Harrison to inspect homes in Australia, although she thought Bindoon "the best of the RC Homes she has ever visited".[40] In the light of such comments, and the qualified approval contained in the Moss Report there is no reason to suppose that an inspector from Northern Ireland would have formed a different view of the circumstances in Australia at that time. **However, we regard the failure of the Northern Ireland Government to make any enquiries whatever as to the fate of these children, whether of the authorities in London or Australia, as further evidence of its complete indifference to their welfare. We regard this as a further systemic failing on its part. As we shall see, it was not until the end of 1956 when the Home Office sent the Ross report that the Northern Ireland Government appears to have given any thought to the issue, and by then the last children had sailed.**

65 In our view, the Northern Ireland Government should have taken greater steps to inform itself of what was happening. If it had done so, it is hard to see how it could have failed to have become aware how many children from Northern Ireland were being sent to Australia when they were of an age at which the Government would normally refuse to consent to their emigration had the children been in statutory and not in voluntary care. In those circumstances we consider that it should have made vigorous representations to the United Kingdom Government to prevent this practice, and not remain indifferent to the practice. **We consider the failure of the Northern Ireland Government to take the steps we have described amounts to a systemic failure on its part.**

40 HAA PP.6/1 1949/H/1168.

The experience of HIA 354 and the lessons to be learnt from that

66 Reference has already been made to the evidence of applicant HIA 354. His evidence, and the voluminous documentary material which has been provided to the Inquiry in relation to these matters, is of considerable importance for a number of reasons, not all of which are directly connected with the circumstances of his own case. However, in order to fully appreciate these considerations it is necessary to set out in some detail the chronology of events, and the background circumstances, of HIA 354 and his siblings. These can be conveniently divided into a number of stages, with the first stage relating to the events leading up to his emigration to Australia.

(1) HIA 354 was a seven-year-old boy who had a younger brother (AU 98) and a younger sister (AU 99) who were orphaned when their mother died in August 1949. All three were then taken into care by Tyrone Welfare Committee (TWC).

(2) Each of the three children had health problems, and although HIA 354 was cleared, at the time he was taken into care his younger brother AU 98 was in Crawfordsburn hospital (the headquarters of the Northern Ireland Tuberculosis Authority). HIA 354 and his sister AU 99 had been taken to Tower Hill hospital, Armagh where they remained until November 1949 when they were amongst the first children to be placed in Coneywarren children's home. On 28 September 1950, AU 98 was admitted to Coneywarren from Crawfordsburn. His sister AU 99 remained in Coneywarren with him until she was boarded out with a foster mother on 9 February 1951. AU 98 was discharged from Coneywarren later that month and boarded out with foster parents in Co. Londonderry.

(3) HIA 354 and his sister AU 99 had therefore been together in Coneywarren for some seven months before HIA 354 was boarded out to his foster parents in Donemana. AU 98 did not enter Coneywarren until 28 September 1950 and so at the very most would have had recent contact with his brother for about a month before HIA 354 went to Australia, although it is not clear from the documents produced to the Inquiry whether any contact took place. None of these matters were made known to the Ministry by TWC.

(4) On 3 July 1950 HIA 354 was boarded out for a three-month trial period with a family in Donemana, Co. Tyrone, who had hoped to adopt a six-year-old boy. For some reason that arrangement had fallen through.[41] AU 99's foster mother was the sister of the foster mother of AU 98, and AU 99 was later boarded out to a foster mother who lived on the same country lane as the foster parents of HIA 354.[42]

(5) By the time HIA 354 was fostered out the Tyrone Welfare Officer was already considering HIA 354 as a possible candidate to go to Dhurringle in Australia. The County Welfare Officer (CWO) said, "being an Australian myself and being intimately acquainted with the Fairbridge Farm School projects, I can appreciate what this opportunity might mean to an orphan boy".[43] He pointed out that the child was in a Presbyterian foster home, and the Presbyterian minister consulted felt that "migration to Australia may afford [HIA 354] more opportunity that [sic] he would have in County Tyrone."

(6) It is noteworthy that it was recorded at the time that "in regard to separating the family, [the Presbyterian minister] feels that the brother's and sister's health condition is such, that it might never be possible to re-unite them".[44]

(7) On 10 July 1950 the CWO wrote to the Reverend Boag, the representative of Dhurringle in Scotland, suggesting that HIA 354 would be a suitable child to send to Dhurringle.[45]

(8) On 17 July 1950 the TWC agreed that the CWO could pursue enquiries regarding the possibility of HIA 354 emigrating.[46]

(9) On 21 July 1950 the foster mother was informed that HIA 354 had to undergo an intelligence test.

(10) On 27 July 1950 HIA 354 underwent an Intelligence Quotient (IQ) test administered by a local doctor,[47] and that record survives.[48]

(11) On August 1950 the CWO wrote to the Ministry of Home Affairs giving brief details of the background of HIA 354 and asking whether

41 AUS 11724.
42 AUS 11931-11932.
43 AUS 11719.
44 AUS 11718.
45 AUS 11269.
46 AUS 11269.
47 AUS 11714.
48 AUS 11703.

the Ministry would approve of the Tyrone Welfare Committee recommending HIA 354 for the migration scheme.[49]

(12) This application was carefully considered by the relevant officials in the Ministry, and a recommendation was made to the Minister of Home Affairs on 9 August 1950 that the Minister should refuse to agree to the proposal. Two passages from that memorandum are worthy of quotation. After referring to the relevant statutory provisions, and in particular section 111 (5) of the 1950 Act, the writer continued "a child of eight years of age is obviously too young to form or express a proper opinion on the advantages or disadvantages of emigration. In the circumstances the Section would appear to debar any prospect of emigration in this case for the present".

(13) The writer then referred to representatives of Dhurringle Training Farm recently approaching welfare authorities in Northern Ireland, stating that it was possible that other requests for information may be received from welfare authorities:

> "Whilst it is difficult to say that what age any particular child may reach the stage of mental development at which he is capable of forming a proper judgement on such a question, it is unlikely that such a stage would be reached before the age of twelve years at the earliest. I think, therefore, that unless the conditions laid down in paragraph (sic) 111 (5) are satisfied we should not agree to the emigration of any child under that age."

(14) A note on that memorandum records that the Minister was spoken to about this matter, and continues:

> "The Minister agrees generally. As it would probably be in the interests of the child (illegible) if he could emigrate under a scheme sponsored by a responsible body such as the Presbyterian Church he would be prepared to approve if a responsible officer or agent of the managing body of the Farm could assume guardianship of the child or other reasonable arrangements made for travel and subsequent care."[50]

49 AUS 11259.
50 AUS 11260.

(15) The Ministry replied to the CWO on 19 August 1950 observing that:

> "the position of orphanage children who are too young to be able to form a proper opinion as to the advantages and disadvantages of emigration is one which has given rise to some concern to the Ministry. Where, however, it is obviously in the interests of any child that he should be allowed to emigrate and satisfactory arrangements can be made for safeguarding the child's interests, the Ministry will not raise any objection to his emigrating under a scheme conducted by a reputable organisation."[51]

(16) On 13 September 1950 the Tyrone children's officer took HIA 354 to Tyrone County hospital where the child was examined for the presence of tuberculosis and cleared. On the same day the children's officer took HIA 354 back to his foster parents' home at Donemana, "and discussed privately with [the foster mother] the proposed migration of this boy. While if selected, she will be sorry to lose [HIA 354] but realises the opportunities he will be afforded in Australia."[52]

(17) On 18 September 1950 the TWC gave final approval to his emigration subject to his being accepted on the scheme.[53]

(18) On 5 October 1950 HIA 354 was interviewed by the representative of the Australian migration authorities at the Omagh office of the Ministry of Labour and National Insurance. The note made of that visit is revealing:

> "[HIA 354] was today interviewed by Mr. Hill representative of Australian Government. The boy was very shy, and would not talk freely."[54]

He was then accepted for the scheme.

(19) On 31 October the necessary instructions and documents for HIA 354 to sail from Liverpool on 7 November 1950 were received in Omagh.[55]

51 AUS 11264.
52 AUS 11688.
53 AUS 11270.
54 AUS 11684.
55 AUS 11658.

(20) On 1 November 1950 the divisional children's officer of TWC called with the foster family to collect clothing and other articles relating to HIA 354 in preparation for his forthcoming migration. The note of that visit reads:

> "There was an air of depression and deep resentment in the [foster family] home at the removal of the boy, and all I could say, was that the decision to send the boy abroad was taken, after long and most careful consideration."
>
> "The decision would prove to be the right one, while the opportunity, from the point of the boy's future was too good to be overlooked".[56]

(21) HIA 354 recalls that he then went to Manor House, Lisburn where he stayed until he and other children were taken to the boat in England.

(22) There can be no doubt that the foster family decided that they wished to keep HIA 354 with them at a very late stage indeed. On 2 November 1950 the husband of the foster family, accompanied by a local Presbyterian minister, called at the County Welfare Committee and asked if arrangements could be made for the adoption of HIA 354. The divisional children's officer reported:

> "I have been requested by [foster father] to call at his house today but I prefer to wait until this matter blows over."

(23) There the matter appears to have rested, and on 7 November 1950 HIA 354 sailed for Australia in the company of several other boys from Northern Ireland.[57]

(24) Two further matters are relevant. The first is that HIA 354 kept in touch with his foster parents in succeeding years. The second is that, as Mr. O'Reilly on behalf of the DHSS&PS pointed out in his closing submissions, "two of the foster families were living almost directly opposite one another, and in the case of a third child the mother in that family was the sister of the mother in one of the other families."[58]

67 Several aspects of this sequence of events cause us considerable concern. Firstly, Tyrone Welfare Committee did not inform the Minister that HIA 354 had two younger siblings who were in their care. Given

56 AUS 11654.
57 AUS 11041.
58 Day 50, 15 September, 2015, p.305.

that one of the matters that the Minister was required to consider under section 111 (5) of the 1950 Act before giving his consent was whether the child was to emigrate "for the purpose of joining ...a relative", it must have been apparent to the CWO that this child being put forward for emigration had a younger brother and a younger sister in the care of his Committee. Had the Minister been told that, then he would have had to have taken into account that if he gave his consent to HIA 354 being sent to Australia that would result in the child being separated from his siblings. The failure of the CWO to inform the Ministry of these matters is all the more surprising given that he had discussed with a Presbyterian minister that if HIA 354 were to be sent for migration then it could lead to the permanent separation of HIA 354 from his brother and sister.

68 The second is that the foster parents of the two siblings were both geographically and in terms of family connections closely connected with HIA 354's foster parents, circumstances that were also of considerable importance.

69 Thirdly, it is arguable that the Minister stretched the definition of "guardian" to include the body responsible for Dhurringle, but as against that it was clearly the policy of the United Kingdom Government to regard the Australian authorities as being the guardian once a child arrived in Australia and that position was a valid one.

70 Fourthly, we are firmly of the view that at that time it was wrong for the Minister to approve an eight-year-old child for emigration to Australia where he had no relatives or friends with whom he could live, but would live in an institution there, no matter how advantageous that course of action may have been thought to be for the child at the time. The Minister's decision flew in the face of the advice of the officials of his own Ministry, and was at variance with the practice in Scotland where the Scottish authorities would not consider a child so young. These were not isolated views, because as long ago as 1928 the view was taken by Belfast Corporation that it could not countenance the emigration of a child in its care under the age of sixteen, save in exceptional circumstances. The Minister's decision was therefore contrary to a substantial body of advice and professional opinion.

71 The next matter is that it is apparent that the Tyrone Welfare Committee did not inform the Ministry of the approach by the foster family to adopt HIA 354. This appears to have been a last minute change of attitude

on the part of the foster parents, and no doubt it would have been administratively extremely awkward if it had been accepted, probably resulting in wasted time, medical fees, and money spent on fitting out the boy for his new life. Nevertheless, it is hard to avoid the conclusion that Tyrone Welfare Committee officers had formed the view that it was in the best interests of HIA 354 to go to Australia as they had arranged, and were not prepared to countenance any change of circumstances at such a late stage.

72 In her statement to the Inquiry, Fionnula McAndrew said on behalf of the HSCB (as the successor body to Tyrone Welfare Committee) that there is no evidence to suggest that this last minute approach was given due consideration.[59] However, we consider that the matter goes further than that, and as Dr. Harrison conceded[60] in her statement on behalf of the DHSSPS, "the record of the visit would indicate that the Welfare Committee was determined that the request would not be further pursued." We are satisfied that the officials of the Tyrone Welfare Committee did consider the matter, and decided to go ahead and send HIA 354 to Australia, notwithstanding that there was a very late proposal for adoption, which, if it had been properly considered, could well have resulted in three children being kept close together in Northern Ireland. **We regard this as only one of several systemic failings in the way that HIA 354's case was dealt with by both the Tyrone Welfare Committee and the Ministry of Home Affairs.** The others are set out in the next three paragraphs.

73 Tyrone Welfare Committee did not tell the Ministry of the existence of HIA 354's siblings, thereby depriving the Minister of important and relevant information which should have been before him in order that he could make a proper and informed decision as to whether or not to give his consent to the child's emigration. Whilst of course it is to some extent speculative whether the Minister's decision would have been any different had he had this information, nevertheless it might well have been.

74 Tyrone Welfare Committee did not tell the Ministry of the approach made by the foster family to adopt this child. **We regard this to be a systemic failing on the part of the Welfare Committee.** Although the approach was made at a very late stage, nevertheless there remained about a

59 AUS 5994.
60 AUS 5972.

week before the anticipated sailing date, and so there was ample time in which to inform the Ministry of this new development and seek the views of the Minister accordingly.

75 The Minister was wrong to take the view that it was appropriate to send a child of eight to Australia in the particular circumstances relating to HIA 354 because the Minister ought to have taken the view that no child of that age could be expected to form, or express, a proper opinion on the advantages or disadvantages of emigration. Indeed it is noteworthy that so far as the Inquiry can ascertain on no other occasion did a Minister of Home Affairs give approval for the emigration of such a young child where that approval was required. **The decision by the Minister reflected a policy that it was appropriate to send a child of eight to Australia. We regard that policy as a systemic failing.**

76 The second stage of the history of HIA 354 consists of his experiences on the voyage from England to Australia. Two experiences are relevant. Despite being only eight he was made take part with other boys in a boxing match for the entertainment of the passengers. On crossing the Equator he was tipped backwards into a tub of water, this apparently being a traditional type of ceremony for those who cross the Equator for the first time, but an experience he found extremely frightening.[61]

77 The third stage commences with his arrival at Melbourne, Australia on 15 December 1950, from where he travelled to Dhurringle. As we have already explained, the Inquiry does not have power to examine his experiences in Australia. For those who wish to consider them, they may be found in his statement and in his evidence to the Inquiry.[62]

78 The next relevant development did not concern HIA 354 directly but concerned AU 98, his younger brother, because in 1952 TWC considered whether AU 98 should be sent to Australia to join his brother at Dhurringle. In the event this suggestion never came to fruition because of concerns about the health of AU 98, and when his health improved some years later he was boarded out with foster parents in Co. Londonderry. The suggestion that AU 98 be considered for emigration to Australia to join his brother shows that TWC was prepared to reunite the two brothers, although that would have meant depriving AU 98 of the possibility of future contact with his sister AU 99 because she was not being

61 AUS 11246.
62 Day 44, 3 September 2014.

considered for emigration and would remain in Northern Ireland.[63] It is clear that it was the Committee's intention that when AU 98 attained the age of eight years "he should if possible, join his brother at Dhurringle Training Farm School".[64]

79 The proposal to send AU 98 to Dhurringle was significant for another reason, because the CWO reported to the Children's Committee of the County Welfare Committee on 1 September 1952 that:

> "…it was decided to make tentative arrangements for [AU 98] to rejoin his brother [HIA 354] at the County Dhurringle Farm Training Centre in Australia but that since then, by indirect manner [the County Welfare Officer] had learned of rather disquieting reports considering the unhappiness of the boys there. He stated that he had written to the Supervisor of the Centre and also to some personal contacts in Australia and that he awaited replies. In the circumstances, it was agreed to defer further arrangements in regard to the migration of [AU 98]."[65]

80 As a result of this "disquieting report" the CWO sought information on HIA 354 from the Presbyterian Church authorities in Australia, and received reassuring reports to the effect that the complaints had been made by a homesick boy within a few days of his arrival, and were trivial.[66] The letter was received on 2 September 1952. However the CWO had made private enquiries through Mr J.T. Massey OBE, a friend who was the National General Secretary of the Committee of the YMCAs of Australia. Mr. Massey's response was that so far as he could gather the conditions in Dhurringle:

> "compare quite favourably with other similar Institutions being run by various Churches. My impression is that it is not as far advanced as some others, e.g. Methodist Church Tally - Home Scheme, but I know of no reason why a boy should not have a great opportunity as a result of attending the school."[67]

81 As that letter was dated 9 October it would not have been available to the CWO, (although the letter of 2 September which has been referred to would have been available to him) when the Reverend A. Bell made

63 AUS 11287.
64 AUS 11755.
65 AUS 11291.
66 AUS 11765.
67 AUS 11763.

a presentation to TWC on 6 October 1952. To judge by the minute of the meeting, his presentation received a polite but non-committal response.[68] It seems likely from the absence of any further reference to these concerns that they must have been allayed by both the official and unofficial responses to the enquiries made by the CWO.

82 The proposal to send AU 98 to Australia was dropped because of his health, but we consider it significant that the suggestion that AU 98 be sent to Australia was not well received by his foster mother, nor by the Co. Londonderry Welfare Committee. Its CWO pointed out that AU 98 was living near his sister AU 99 "who could not go to Dhurringle" (presumably because that was an all boys institution). Co Londonderry also criticised Tyrone because no indication had been given to his foster mother that the boy might be sent to Australia when she had taken him, nor had they discussed with her beforehand that they were now considering sending him to Australia to join his brother. Not surprisingly, the foster mother was extremely upset when she learnt of this plan. We consider the relevance of this to be that it is a further indication that the Tyrone Welfare Committee did not give any, or at least proper, weight to the desirability of keeping as many of the children of this family together as possible.

83 The third stage of the history of HIA 354 relates to the efforts of TWC to keep in touch with him in Australia. An initial report from Dhurringle was received in September 1951, but although further letters were sent on 11 June 1952, 8 July 1952 and 14 August 1952, no replies were received. At the same time, steps were being put in hand to send AU 98 to Dhurringle and although there was a response to a separate letter of 11 June 1952 containing some information from the Reverend Boag, who said he had asked the Superintendent of Dhurringle to send an official report[69], it would seem that no such report was sent.

84 Despite the lack of further information it would appear that no further enquiries were made about HIA 354 until 1956. During that time HIA 354 has said he and his sister wrote to each other every couple of months[70] and this would appear to be confirmed by a reference in a letter of 7 September 1956[71] to AU 99 being "terribly disappointed at

68 AUS 11293.
69 AUS 11759.
70 AUS 11249.
71 AUS 11435.

not receiving a letter from him since March 1956". Therefore, whilst HIA 354 only wrote to his brother once or twice, there does appear to have been a much greater and continuing level of correspondence between himself and his sister.

85 The letter of September 1956 from the Children's Officer of TWC was to the secretary of the Department of Social Service, which was the body of the Presbyterian Church in Australia responsible for Dhurringle. She requested a full report on HIA 354 and a photograph. She also said that if she did not hear from the Department she "would be forced to take the matter up with the High Commissioner".[72] This letter had the desired effect because a detailed report dated 20 September 1956 was received. Although this letter suggested that the previous superintendent may have failed to deal with the earlier letters, as the writer had been in post since 1954 he did not explain why he had not followed his professed practice of sending six monthly reports on HIA 354 as he said he did in respect of other boys sent by overseas organisations. Thereafter detailed progress reports about HIA 354 were sent by Dhurringle to TWC on a regular basis until he reached the age of twenty one and so ceased to be their responsibility.[73]

86 We have set out this stage of HIA 354's history at length because it shows what could be done by a welfare committee, and therefore by another body with the will and the means to do so, to keep in touch with the children it had sent abroad, and to ensure that siblings or other family members who tried to do so could maintain contact with those children who had been sent to Australia.

87 Whilst Tyrone Welfare Committee's efforts to get information about HIA 354 were commendable in virtually every respect, it must be noted that the records suggest that it did not take any steps to get information between the cessation of letters in 1952 for four years until further correspondence was initiated by it in 1956. Had the determined and successful course of threatening to write to the High Commissioner been attempted earlier then that gap might not have occurred. Although we consider that the gap should not have happened, nevertheless it seems to be the position that during the gap Tyrone Welfare Committee was aware HIA 354 was in regular contact with his sister AU 99, and so we do not consider that this lapse on the part of the Tyrone Welfare

72 AUS 11436.
73 AUS 11598.

Committee, whilst significant, should be regarded as a systemic failing by it in view of its other efforts.

88 The history of HIA 354 also throws light on the approach of the Ministry of Home Affairs to the question of child migration initiated by county welfare committees, and enables us to see almost the entire administrative process involved in child migration. We have already considered some of these in preceding paragraphs, but others that are of wider significance to issues which we will examine later can be summarised as follows:

(1) He underwent a formal interview with an Australian immigration officer.

(2) He was examined as to both his physical and intellectual capacities, something that was organised at the insistence of the Australian authorities.

(3) Those, such as his brother AU 98, who did not come up to the physical and intellectual standards required by the Australian authorities were rejected.

(4) In the case of Dhurringle regular reports on the children would be sent to the organisation which had sent the children to their care in Australia.

(5) If such reports were not sent back, then the sending organisation was able to pursue that information, and, if information was received, pass it onto the siblings or other family members.

(6) Direct contact between the child and its siblings in Northern Ireland was certainly feasible, and facilitated by Dhurringle at least, as a normal procedure.

Irish Church Missions

89 The Society for Irish Church Missions (previously known as the Irish Church Mission to the Roman Catholics) is a society run by clergy and laity of the Church of Ireland within the wider Anglican communion, and although its principal address is in Northern Ireland, its registered office is in England. For many years until 1984 the Irish Church Missions (ICM) ran a children's home in Lisburn, Co. Antrim, known as Manor House. In the 1940s and 1950s Manor House was attached to the Church of Ireland Parish of Christ Church, Lisburn, and as appears elsewhere in this Report the way in which Manor House was run has been investigated by the Inquiry. The ICM published a magazine called

The Banner of the Truth in Ireland and reference will be made to this, and to written submissions made to the Inquiry by the ICM. The ICM did not appear, nor was it represented, during the hearing of the second module dealing with Australia, although it was informed of the dates on which evidence would be given relating to it, and when it could make any further submissions.

90 The connection of the ICM with the child migrant scheme is twofold. In November 1950 seven boys from Manor House accompanied HIA 354, as did two other child migrants who were sent to Australia by the County Londonderry Welfare Committee. These may well have been AU 110 and AU 111 referred to above. In 1969 three more boys from Manor House emigrated to Australia. These were HIA 365, HIA 290 and their half brother AU 83. HIA 365 and his twin brother HIA 290 were fourteen and nine months of age when they emigrated, and AU 83 was thirteen. These three children migrated with their father at his request, and in view of that, and the fact that they were in their teens, the Inquiry has not considered their experiences as child migrants. However, HIA 365 and HIA 290 made serious allegations about the way they were treated as children in Manor House and these are considered elsewhere in the section of the Report relating to Manor House.

91 Although a minute of the proceedings of the committee of the ICM written in the 1960s said that six boys went from Manor House, this is inaccurate. Both the June 1951 issue of *The Banner of the Truth in Ireland*,[74] and a committee minute of 2 November 1950[75] both say that seven boys went, and that it is confirmed by the passenger manifest which records that seven boys were sent by the home. Two of the seven boys are applicants to the Inquiry. HIA 341 was nine years and six months of age when he was sent, and HIA 346 was eight years and ten months of age when he was sent.

92 HIA 346 described how he was in Manor House from the age of six, having been placed there at the time by his unmarried mother. Although he describes her as visiting him regularly at the home, the consent form in his case was signed by the matron of the home on 20 July 1950. He claims that his mother, who married on 2 July 1949, told him in later life that when she and her husband came to Manor House to take him home, she was told that he had been adopted by a wealthy family in

74 AUS 11063.
75 AUS 11061.

Dublin.[76] In his written statement HIA 346 described how he obtained his school records, which he said showed that he was taken out of school for a period of about one month. He believes that that was when his mother, her husband and her stepchildren came to the home to collect him. However, the Inquiry has been informed that the school records no longer exist and therefore this cannot be confirmed.

93 The mother of HIA 341 did give consent to his being sent.[77] If his mother did visit regularly it might be thought that Manor House may have been able to contact her to ask whether she did consent, but it may be that they could not contact her, and since HIA 341's mother did consent we cannot be satisfied that Manor House did not try to contact HIA 346's mother.

94 Although the surviving migration records suggest that both underwent medical examinations, neither can recall these. The ICM has no records relating to interviews by the migration authorities of either child, or of either child being made to sit intelligence tests of any sort. However, given that the Inquiry is satisfied that these steps were normally carried out, it may well be that they did undergo some form of intelligence assessment. If so, it is not surprising that neither applicant can recall any such event, which would have occurred when they were eight and nine years of age respectively.

95 HIA 346 alleges that on the voyage he was kept short of food,[78] and whilst HIA 341 does not allege that he was kept short of food or ill-treated on the voyage, it should be noted that HIA 354 says he was made to box against his will on the same voyage.[79]

96 In later years both applicants had considerable difficulty establishing contact with their parents. HIA 341 did write to Manor House in the early 1960s in an effort to contact his mother and the Manor House authorities replied saying that they had not been able to trace her. Fortunately, HIA 341 was able to trace his mother by using a genealogist he employed for that purpose. HIA 346 did not try to find out any information about his family until many years later, when he was reunited with his mother through the efforts of the Child Migrants Trust.

76 AUS 11118.
77 AUS 11032.
78 AUS 11119.
79 AUS 11246.

97 We accept that the various preliminary procedures that have already been described in respect of HIA 354 were probably carried out for HIA 341 and 346 because all three were sent to Australia on the same boat, and it appears likely that the elaborate procedures applied to HIA 354 at the insistence of the Australian migration authorities were applied to HIA 341 and HIA 346 as well.

98 **We are satisfied that Irish Church Missions were guilty of a systemic failing in sending children of this age to Australia.** Whilst we accept they took the view that the children would have greater opportunities in Australia than they had in prospect in Northern Ireland, nevertheless it was wrong to send children of that age to Australia, even where, as in the case of HIA 341, a child's mother gave consent, because we are satisfied that the initiative for the child being sent came not from the mother but from the ICM.

99 HIA 346 said that he received no communication from Manor House after he left in 1950. Apart from a report in 1951,[80] it would seem that no information was received on these boys until 1961 when a letter came from Dhurringle.[81] No evidence has been provided to us to suggest that ICM took any steps to keep in touch with their children in Australia for a decade after they were sent. The information they received in 1961 was sent from Australia, and not sought by them. **We are satisfied that ICM failed to make sufficient efforts to stay in touch with the children in later years, and consider that this failure amounts to a systemic failing on their part.**

100 HIA 346 said that when his mother asked for him later she was told that he had been adopted by a wealthy family in Dublin. We consider him to be a reliable witness, and we accept that his mother was misled in this way. **We also regard this as a systemic failing on the part of ICM.**

The Sisters of Nazareth

101 The Sisters of Nazareth were involved with child migration well before the children who are being considered by this Inquiry were sent to Australia. It appears that they sent children to Canada in or before the 1920s. In 1923 the General Chapter considered an approach from a Major Macaulay who suggested that the Sisters might send children

80 AUS 11063.
81 AUS 11064.

aged about twelve to Australia. This proposal was put before the General Chapter by the Mother General. She suggested that if the children were to be sent they should go to Brisbane in Queensland after a suitable arrangement had been made with "Archbishop Duhig, who is also anxious for Catholic girls to go there." The General Chapter agreed that the scheme would be a good thing and it is recorded that "the scheme would need to be well thought out."[82]

102 A further discussion took place at a General Chapter in 1925. The Mother General referred to the earlier approach two years before, and it would seem that in the intervening period someone from the Order had visited Australia and spoken to Archbishop Duhig, "who not only approved of and encouraged the proposal but was prepared to get a hostel for them, but this we shall not require as we have now a large house in Brisbane." The proposal was to send out about 20 girls "from 12 to 16 years old." Queensland was favoured because it "is a very Catholic State and considered the best for our girls." They would be sent to the Sisters' home in Brisbane in the first instance "where they could help with the work and be trained more or less for situations for about two years or so. There are much better openings for girls in Australia than at home, and as a rule, they get on better."[83]

103 The Sisters were clearly anxious about the way children would be selected to be sent because the minutes continue:

> "Care must be taken in the selection of these children so as to send out sensible, well developed healthy girls who are likely to turn out well, otherwise they may not get a good name for Nazareth House and we may not be able to continue sending them."

The minutes refer to the availability of assisted fares, children under twelve going free and those over twelve for £5 10s each. The majority approved of the scheme "if it could be worked out – it would help to spread Catholicity." One superior remarked that sending out children to Canada through the Catholic Emigration Society was very satisfactory.

104 The matter was considered again at a General Chapter in 1928, and it would seem that a number of girls had been sent in the intervening period of time, as the minutes record:

> "Reports very satisfactory of girls who had emigrated under the care of our Sisters, and being received in our house at Brisbane. The

82 AUS 5386.
83 AUS 5389.

> Bishop there is very interested in the scheme. A site for a new foundation has been procured in Melbourne, this house might be used to receive children emigrated from the Home houses."

The same minute refers favourably to reports of the children who had emigrated to Canada under the care of the Catholic Rescue Society, saying that "Reports of these children are good and the supervision exercised over them in Canada is highly satisfactory."[84]

105 The matter seems to have rested there until 1938 when a fresh approach was made to the Mother General about a scheme for the emigration of boys to Western Australia. The *History of Foundations* provided by the Sisters of Nazareth records that on this occasion the scheme was for the emigration of boys to Western Australia under the auspices of the British Government, the Commonwealth and State governments. The records state that "Rev Brother Conlon of the Christian [Brothers] Schools was the chief organiser." Other entries in the History of Foundation describe boys being hurriedly selected and sailing on 8 July, apparently arriving in Australia on 9 August. There were 25 boys in the first party, and another party of about 30 went in the week of 16 July. It appears that one boy from Nazareth House Belfast was included in a further group as he is recorded by the Sisters as sailing on 29 August 1938. Two boys from Termonbacca sailed on 17 February 1939. The Australian Senate Report records that in 1938, 68 boys and one girl were sent by the Sisters, and in 1939 46 boys were sent.[85] Therefore three of these boys were sent by the Sisters from Northern Ireland to Australia before the outbreak of the Second World War brought this scheme to a rapid end.

106 The initiative for British Catholic children to be sent to Australia came from the Christian Brothers in Australia. In *Changing Times Changing Needs A History of the Catholic Children's Society* (Westminster) (2009) Jim Hyland states that the Christian Brothers made a plea for 100 English Catholic boys to be sent to the newly established farm school set up by the Christian Brothers in Western Australia, and that when the approach was made in 1938 Cardinal Hinsley, the Cardinal Archbishop of Westminster at the time, and the Catholic Emigration Association "agreed reluctantly to support the idea." Hyland reports that in 1938 the Christian Brothers were approached by the London County Council

84 AUS 5391.
85 *Senate Report* 2.52.

with a request to establish a scheme for girls, and that it was hoped that the Sisters of Nazareth would run a project for girls in one of their Western Australia projects, which they later did.

107 Hyland quotes a letter from Canon Craven, the Administrator of the (Catholic) Crusade of Rescue, written in 1939 to Bishop (later Cardinal) Griffin of Father Hudson's Society in Birmingham (a society of which Bishop Griffin had been Administrator). Canon Craven said that whilst he supported the plans:

> "I should myself have been very much opposed to girls going out simply to be trained for domestic service and I ought to tell you that the [London County Council] were absolutely opposed to such a scheme. They are afraid, like myself, that it would mean using poor girls as drudges on farms and in the towns. This we must certainly prevent."[86]

Hyland records that:

> "It was agreed by the Bishops of England and Wales in February 1939 that the Catholic Child Welfare Committees (CCWC) of which the Crusade of Rescue was a member should have exclusive control and management of the emigration and settlement of all children up to the age of seventeen. The outbreak of World War II put an end to all such activity until 1945."[87]

The Role of the Roman Catholic authorities in arranging post-war child migration

108 There can be no doubt that the Roman Catholic bishops in Australia, and in Western Australia in particular, were extremely anxious to encourage the migration of Roman Catholic children to Australia before and after the Second World War. Archbishop Redmond Prendiville was the Roman Catholic Archbishop of Perth at the time. In 1947 when welcoming the first group of 147 Catholic child migrants to arrive in Perth after the resumption of child migration following the end of the Second World War he is reported to have said that "At a time when empty cradles are contributing to empty spaces, it is necessary to look for external sources of supply."[88] Hyland records[89] that in May 1945 Archbishop

86 Hyland, *Changing Times Changing Needs*, p.74.
87 Ibid, p.75.
88 *The Record*, 25 September, 1947. *The Record* described itself as the "Official Organ of the Archdiocese of Perth".
89 Hyland, *Changing Times Changing Needs*, p.75.

Prendiville wrote to Cardinal Griffin seeking the Cardinal's agreement to restarting child migration. As can be seen from a booklet published by the Christian Brothers publicising the schemes which they ran in Western Australia, the Archbishop publicly commended the Christian Brothers for their efforts, saying:

> "I wholeheartedly commend the proposal to arrange for the reception of children from the United Kingdom at the Institutions in Western Australia and commend the Catholic Episcopal Migration and Welfare Association which is to arrange and control the migration scheme."[90]

109 Hyland also records that in May 1946 Cardinal Griffin wrote to Canon Craven at the Crusade of Rescue "about the pressure he was having from the Church in Australia and suggesting a meeting of the Catholic Child Welfare Council to discuss the issue." Significantly, in the light of what the Inquiry heard about the experiences of many of those children who were sent to Australia by the Sisters of Nazareth, Hyland continues:

> "The Cardinal also refers in his letter to 'adverse reports' about Australia of which he thought Brother Conlon, of the Australian Christian Brothers schools should be made aware. Canon Craven replied that he was not aware of such reports but agreed that if they existed Brother Conlon should be told about them. He added that he believed that before any further migration of children began the whole issue needed to be explored on the spot in Australia."[91]

110 At the subsequent meeting of the CCWC it was noted that the Australian Government was seeking 70,000 migrants a year, of whom they expected 17,000 would be children. Hyland states "They agreed that someone from the Council should visit Australia before resuming the scheme, although there is no record of anyone going at this time."[92] He refers to Brother Conlon travelling around England and agreeing with various Catholic agencies the number of children who could be sent to Australia. Brother P.A. Conlon was the moving spirit behind, and was closely involved in arranging, the child migration of Roman Catholic children to Australia before and after the Second World War, although he was not the only person so involved. It is clear from the material presented to the Inquiry by the Sisters of Nazareth, and the material submitted

90 AUS 2592. See *The Christian Brothers' and associated schemes for the training of boys and girls in Western Australia* (Perth, no date), p.4.
91 Hyland, *Changing Times Changing Needs*, p.75.
92 Ibid, p.76.

by them to the Australian Senate and contained in the Senate Report, that the Sisters sent a substantial number of children to Australia from their homes throughout the United Kingdom, and not just their homes in Northern Ireland, following the initiatives by Brother Conlon and others.

How many children were sent to Australia by the Sisters of Nazareth?

111 Figures prepared by the Sisters of Nazareth for the Australian Senate and supplied by the Sisters to this Inquiry record that 1,109 Roman Catholic children from the United Kingdom were sent to Australia between 1938 and 1956, 775 of whom were sent by the Sisters of Nazareth. It has proved extremely difficult to establish exactly how many children from Northern Ireland are included in the total number of children sent to Australia by the Sisters of Nazareth. The Sisters informed the Inquiry that 122 children were sent by the Sisters from their institutions in Northern Ireland, and if that figure is correct it represents over 10% of the total number of children sent by the Sisters of Nazareth from the United Kingdom to Australia as child migrants. When the Inquiry asked that inconsistencies in the figures provided to it be resolved, further investigation by the Sisters resulted in their modifying that figure and giving the names of 111 children. However, there is information which suggests that ten girls from Northern Ireland who sailed for Australia on 8 February 1950 are not included in the revised total of 111. That suggests that the total may have been at least 121 or 122.

112 It has not been possible to identify all of the children who sailed on 8 February 1950. The Congregation has informed the Inquiry that the records relating to this sailing appear to be missing, although there are other documents which show that children did go on that occasion, notably an entry from the *History of Foundation* for 1950 which records that two sisters left for Australia on the *Asturias* on 8 February 1950 escorting child migrants from Nazareth Houses in Birmingham, Belfast, Aberdeen and elsewhere.

113 One of the ten was HIA 326, an applicant to the Inquiry. The Inquiry has not been able to resolve this discrepancy, and so the best judgement we can make is that at least 111 children were sent to Australia by the Sisters, but it may be that as many as 127 were sent. That is because although the total of 122 in the following table includes the ten who appear to have sailed on 8 February 1950, there were a further five

children from Sligo who are not included in the figure of 54 shown in the table below as having sailed on 29 August 1947, and we consider the five children from Sligo separately.

SAILING	NAZARETH HOUSE, BELFAST (F)	NAZARETH LODGE, BELFAST (M)	NAZARETH HOUSE, DERRY (F)	TERMON-BACCA (M)	
29/08/1938		1			**1**
17/02/1939				2	**2**
29/08/1947	9	6	12	27	**54**
10/10/1947		2			**2**
08/02/1950	?	?	?	?	**10?**
29/01/1953				16	**16**
10/03/1953	2	1			**3**
18/03/1953		2			**2**
08/05/1953	6			5	**11**
23/02/1955	5				**5**
21/02/1955	1				**1**
24/12/1956	1	14			**15**
	24	26	12	50	**122**

(**F** = female, **M** = male)

Children from Nazareth House, Sligo and children born in the Republic of Ireland

114 A curious feature of the information supplied by the Sisters of Nazareth to the Inquiry is that it suggests that six boys were sent from Nazareth House in Sligo to the Sisters' House at Termonbacca in Londonderry, five of whom appear to have sailed to Australia on 27 August 1947 with other boys from Termonbacca. That is stated in Sr Brenda's statement of 6 July 2014,[93] and in other documents supplied to the Inquiry by the Sisters,[94] although the names of the five boys do not appear on the list of 111 children referred to earlier. Two of the five, HIA 302 and HIA 333, applied to the Inquiry. Information provided by the Sisters suggests that a third child from the group of five also sailed, but none of the three appear on the list of 111 children. A fourth child who was on Sr Brenda's list as

93 AUS 11409.
94 AUS 12138-42.

having sailed to Australia contacted the Inquiry and confirmed he did not go to Australia. This is a further illustration of the extreme difficulty faced by the Inquiry in trying to reconcile conflicting information provided by the Sisters to establish a reasonably definitive list of all the children the Sisters sent to Australia.

115 As HIA 302 and HIA 333 were sent to Australia it appears likely that three of the other four children from Sligo went with them, making five in all, although some documents provided by the Sisters suggest that only three out of five actually went. We have not been able to establish why the five children were sent from Sligo to Termonbacca before they were sent to Australia. So far as can be ascertained from various documents produced to the Inquiry by the Sisters, four of the five children who we think were likely to have been sent to Australia were born in Northern Ireland. Although HIA 333 was born in Co. Monaghan his mother may have been a native of Co. Fermanagh. The legal position relating to the citizenship of such children under the law of the United Kingdom and the Irish Free State at that time is complex, and because of the limited information the Inquiry has about the children and their parents we cannot form any view as to whether at the time they moved from Sligo to Termonbacca all or some of the five children would have been regarded as citizens of the Irish Free State under its law, or of the United Kingdom under its law, or citizens of both. It is possible that there was other information available to the Sisters that has not survived, which led the Sisters to regard all five (and not just the four born in Northern Ireland) as Northern Ireland children, but that must remain speculation. What we can say is that we regard it as likely that all five were sent to Australia from Termonbacca on the first sailing on 29 August 1947. One was aged 10, one was 12, two were 11, and the fifth was 5. We therefore consider it likely that at least 117 children, and quite possibly as many as 127, were sent to Australia by the Sisters, all but three of whom were sent between 1947 and 1956.

116 Other applicants born in what was then the Irish Free State, and is now the Republic of Ireland, also complained to us that they should not have been sent to Australia because they were not British children. HIA 307, one of the Australian applicants who had been in Nazareth Lodge in Belfast, gave evidence during the fourth module.[95] He was one of the final group of child migrants from Northern Ireland who sailed on 24 December

95 Day 84.

1956, and he believes that because he was born in Dublin it was illegal for him to be sent to Australia. However, as in the case of those children discussed in the previous paragraph, there is insufficient evidence about his mother to enable the Inquiry to reach any conclusion about the legality of his or other children born in the Irish Free State being sent to Australia as a child migrant.

117 Therefore the Sisters sent three children in 1938 and 1939, and possibly as many as 124 more children spread across ten sailings to Australia between August 1947 and December 1956. The first sailing after the Second World War was on 29 August 1947 and contained 54 children from all four Nazareth House institutions in Northern Ireland. The last sailing left on 24 December 1956 and contained fourteen boys from Nazareth Lodge, and one girl from Nazareth House, in Belfast. It is significant that no children were sent from Londonderry after five boys went from Termonbacca on 8 May 1953, and SND 482[96] said he remembered SR 11 saying that no more children from Termonbacca were going to Australia. Although the Congregation as a body decided to support the migration of children to its homes to Australia, as each house was semi-autonomous it was for the mother superior and her local council in each house to decide whether to take part in the child migrant scheme, and if so, how many children each house would put forward for emigration. No children from Termonbacca were sent after 1953 and, at the latest, girls were sent from Nazareth House, Bishop Street in 1950, whereas girls from Nazareth House, Belfast, and boys from Nazareth Lodge, Belfast, were sent until 1956.

118 The Congregation has not been able to provide a definite explanation as to why there was a different approach between the Belfast and Londonderry homes, but it appears to us that it may possibly have been due to greater pressure on accommodation in the Belfast homes. That may be inferred from a remark contained in a report by Miss Forrest to the Ministry of Home Affairs in November 1955 that the Mother Superior of Nazareth Lodge said that she was contemplating sending 23 boys to Australia soon, and may send another 20 later. Miss Forrest continued "Rubane can't absorb all their output and this is how they are to be disposed of."[97] Whether the words "disposed of" were those of Miss Forrest or those of the Mother Superior may be open to interpretation. In

96 Day 32, 7 May, 2014, p.16.
97 AUS 5160.

the event it seems that the boys were not sent. So far as the Londonderry homes were concerned, the remark attributed to SR 11 would suggest that there was reluctance on the part of both homes in Londonderry to see their children go, and thereby change the character of the home.

119 Many of the girls sent from Northern Ireland went to Sisters of Nazareth houses in Western Australia, although it would seem from the *History of Foundation* entry for 8 May 1953 that the girls from Nazareth House in Belfast were to go to the Nazareth House in Melbourne, New South Wales. Incidentally, that entry states that there were five children, although the figures submitted to the Inquiry by the Sisters say that six children went on that occasion. Girls who did not go to homes run by the Sisters of Nazareth went instead to the Sisters of Mercy at Subiaco, Western Australia. It appears that all the boys went to homes in Western Australia run by the Christian Brothers.

Ages of children selected for migration

120 In her *Analysis of computerised database*[98] which examined all the available information held by the Sisters of Nazareth relating to 1,147 children sent to Australia from the United Kingdom by Roman Catholic religious orders and organisations, Rosemary Keenan commented that "The highest single percentage of children sent [from the United Kingdom as a whole] were eight year olds with about half of all children aged between 7-10 years of age."[99] As can be seen from the table below the pattern of the ages of 117 children sent from Northern Ireland by the Sisters whose dates of birth we have was similar to the age pattern for the whole of the United Kingdom (the numbers in brackets are the totals when the ages of HIA 326 and the five children from Sligo are included).

98 Submitted in 1996 to the Select Committee into Child Migration of the Legislative Assembly of Western Australia.

99 Former *Child Migrants to Australia: analysis of computerised database* (3rd edition August 1996), page 3.

Age	Number
4	2
5	11 (13)
6	9
7	14
8	21
9	15
10	10 (11)
11	9 (11)
12	7 (8)
13	7
14	2
15	2
16	1
17	1
Total	**111 (117)**

Therefore, out of 117 children identified to the Inquiry by the Sisters, or which the Inquiry believes were likely to have been sent, 85 were ten or younger, 57 or 59 were eight or younger, and of this group two were four years old, thirteen were five years old, and nine were six years old. Only six of the 117 were over fourteen. This pattern of the majority of children being ten or younger reflected a deliberate policy on the part of the Roman Catholic Church in Australia. Keenan observed that "The majority of children sent were between the ages of five-thirteen years, the Roman Catholic Church preferring younger children to be sent."[100] Three examples show that it was a deliberate policy to send such young children. In June 1946 Br Conlon wrote to Dr Farren, the then Roman Catholic Bishop of Derry, seeking permission to visit the homes or institutions in his diocese "with a view to select suitable children, boys and girls, between the ages of five and fourteen for the Australian Bishops' migration scheme."[101] On 21 March 1952 Fr. Nichol wrote to the mother superior in Termonbacca, and enquired whether there were any boys she might suggest for emigration, saying "The age groups

100 P.3.
101 AUS 5364.

should be as follows: eight-twelve and five-six. In the case of brothers we are prepared to extend the ages either way."[102] That the Sisters were quite willing to send children as young as five was confirmed by the Superior General of the Congregation in her circular letter of the same day to superiors when she emphasised that "only normal children from five to ten years of age are to be emigrated and this is the responsibility of Superiors and Sisters in charge of the children."[103]

121 The Sisters of Nazareth were not alone in sending young children, although it was unusual for children under seven to have been sent, if the approach of Dr Barnardo's (now known as Barnardo's) is typical of other organisations which sent children to Australia. When explaining its approach in 1955 Barnardo's stated:

> "The best age for children to make the move is when they are between seven and twelve years, but when a family group is involved such a limiting condition need not apply. Normally girls should not migrate between the ages of thirteen and seventeen years."[104]

Parental consent

122 One of the matters about which the great majority of applicants were most bitter was whether their parents (almost always the mother) were asked to consent to their child being sent to Australia. Many allege that their parent was not asked for their consent, or were lied to, when the parent returned to the home to see, or take back, their child. HIA 330 is such a case. She says that her mother told her in later years that SR 139 gave the authority for her to go to Australia but her mother was never asked. HIA 274, another applicant born in the then Irish Free State, said:

> "I was sent to Australia without my mother's consent or knowledge and from that day I lost my identity and all connections to my family, my home and my country."[105]

It would seem from the information provided by the Sisters that hers is one of a large number of cases where they are unable to provide information to show that the consent of the child's parent was sought.

102 AUS 12178.
103 AUS 5407-08.
104 Module 8, BAR 19050.
105 AUS 10083.

123 There is ample evidence that the Sisters were well aware that parental consent was required in those cases where the parent(s) could be traced, and that they tried to contact a parent (usually the mother where the child was illegitimate). For example, in the *History of Foundation* of the Carlisle house of the Sisters of Nazareth an entry in July 1938 relating to eight boys who left for Australia recorded "We were sorry that we were not able to send a greater number but we could not get the consent of their relatives." An undated letter sent by Canon Cyril Stinson to the Mother Superior of Termonbacca contained a list of sixteen boys who had been accepted for emigration and who were due to sail on 28 January, presumably the sailing which actually occurred on 29 January 1953. The letter also referred to a list of names of children submitted by Termonbacca for a future sailing. Canon Stinson said "Could you let me know…whether or not we have to get parents' consent." Finally he says "I understand [AU 32] was withdrawn because his grandmother refused consent."[106] A circular letter of 21 March 1952 from the Superior General to all superiors said "be careful not to select children belonging to people who may object to their going."[107]

124 In December 1955 the Catholic Child Welfare Council (the CCWC) wrote to the mother superior at Termonbacca in relation to "the eleven boys whom you wish to emigrate to Australia." This letter referred to the necessity to "have the parents' consent form signed in triplicate and duly witnessed. This matter is of special importance owing to a new ruling from Australia House."[108] A further letter from the Secretary of the CCWC to the mother superior at Termonbacca dated 17 January 1956 also referred to the necessity to send a brief history of the child to Australia giving:

> "…the date and reason of the child coming into care, whether or not the parents had been in contact with the child and a few details regarding the physical and educational history and religious practice of the child up to the present date."

The final sentence of the letter (which is hard to decipher) reads:

> "Should the mother still be in contact with the child, then you should state that the mother (wishes?) the child to be emigrated for the future benefit of the child. I trust that is clear."[109]

106 AUS 5208.
107 AUS 5407-08.
108 AUS 5209.
109 AUS 5212.

125 At various times the Sisters of Nazareth have attempted to identify those cases where it can be established that parental consent was obtained, and they have conceded that in the majority of cases their records do not allow them to show this. In her *Analysis of computerised database*, already referred to, Keenan concluded that "Consent by birth parent(s) was given to the migration of children in 219 instances (19%). In 913 (80%) instances it is unknown whether or not parental consent was given as the documentary evidence remains unfound."[110]

126 In their final written submissions at the end of this module of the Inquiry the Sisters argued that there were references in their records in Hammersmith, and in the evidence of some applicants to the Inquiry, that suggested that the Sisters had obtained, or from which it could be inferred that they had tried to obtain, parental consent in many cases. They base this submission on references in their records, which they suggest refer to efforts to get parental consent in 48 of the 111 cases where the Sisters accept they sent children from Northern Ireland to Australia, sixteen of whom are applicants to the Inquiry.[111] An analysis of the often cryptic comments extracted from the Sisters' records in Hammersmith suggests that these 48 cases fall into three broad categories. In twenty cases the only known parent could not consent because they were either (a) dead, (b) mentally ill, or (c) could not be traced. In thirteen cases the entries suggest that (a) the mother had handed responsibility for the child to the Order, or (b) did not want the child, or (c) the parent or relative had consented. The remainder do not expressly state whether the parent could or could not be traced, although that might be inferred in some cases, as where the father of three children was described as "a pedlar". In two cases where the mother was described as "irresponsible"[112] the children were sisters and their mother was declared a person in need of special care under the Mental Health Act (Northern Ireland) 1948. She was admitted to the Good Shepherd Convent in Newry, and so both applicants might be added to the twenty already referred to. In the case of HIA 284 it is said the applicant "had rickets on admission" which gives no indication

110 P.4.
111 AUS 8179-8182. Fifteen gave evidence in Module 2. One (HIA 279) gave evidence in Module 3. In addition one (HIA 474) only applied to the Acknowledgment Forum and in one case (HIA 395) the file was closed, and so neither have been considered by the Statutory Inquiry.
112 HIA 303 and HIA 401.

whether or not his parent consented. He told the Inquiry that while he agreed to go to Australia the sisters at Termonbacca told him he had no family.

127 Instances such as this make it difficult, and sometimes impossible, to decide in an individual case whether parental consent was sought or not, given the passage of time, the deaths of those involved, and inadequate records held by the Sisters. However, even if all 48 cases are regarded as cases where a genuine effort was made to obtain parental consent, they represent only 43% of 111 children the Sisters accept they sent to Australia (and, as pointed out earlier, the actual number might be as high as 127). Whilst that is a significantly higher proportion than the 19% of all the United Kingdom cases analysed by Rosemary Keenan in 1996, it means that in more than half of the 111 cases the Order cannot show that parental consent was sought, let alone obtained, where that was possible. Although many applicants asserted that their parents had not in fact consented, a number of witnesses who gave evidence to the Inquiry in module one confirmed that their parents were approached and refused their consent to their children being sent to Australia.

(1) HIA 121 said that he learnt from his mother and father in 1965 that they took him and his brother off a list of boys who were due to go to Australia. However it is unclear from his account whether his parents learnt about the proposed emigration by accident or were formally consulted. He also said[113] that he remembered the nuns talking about the boys going to Australia, and a nun walking along a line with a doctor to select the boys.

(2) HIA 66[114] described how what he referred to as the "emigration people" came and picked people out.

(3) HIA 151[115] said that he remembered a line of boys being selected for Australia when he was about seven. However, as the last group went in 1956 when he was four he is clearly mistaken about the dates.

(4) HIA 235[116] said that he learnt from his cousins that his mother wouldn't allow him to be taken to Australia.

113 Day 5, 29 January 2014, p.66.
114 Day 19.
115 Day 19.
116 Day 4, 28 January, 2014, at p.108.

128 A further issue is that two applicants have alleged that their migration forms were not in fact signed by their parents. HIA 273[117] said that she did not believe that it was her father's signature on the form, although she declined to say why. We note that the signature was witnessed by the chaplain of Nazareth House, Ormeau Road, Belfast. HIA 308[118] doubted that his mother signed. That signature was also witnessed by a Roman Catholic priest. We are unable to reach a firm conclusion about these allegations. Eight applicants said that their parents told them that when they (or other relatives) approached the Sisters to enquire about their child the Sisters lied to them about their whereabouts, saying the child was no longer there or, in four cases, that the child had been adopted. These applicants came from Termonbacca, Nazareth House in Londonderry, and Nazareth Lodge in Belfast, and were sent to Australia in 1947 and 1953. The allegations relate to different homes at different dates, and we see no reason to disbelieve them, indicating as they do that there was a pattern of behaviour by the homes indicative of an attitude that they had made the right decision for the children and it was not in the interests of anyone for the parents to re-establish contact with their child. Whilst it may seem strange today that a parent would not pursue the matter more vigorously, given the high regard in which the Sisters were held, and the deference paid to religious institutions by many Roman Catholics at that time, it would not have been easy for a single parent who had placed a child in the care of the Sisters then to question the actions of the Sisters.

129 It is not now possible to say in every case whether the Sisters did attempt to contact every parent who was alive at the time to obtain that parent's consent to their child being sent to Australia. Looking at the evidence as a whole, we can only say that there is a considerable body of evidence to show that the Sisters did make such efforts, although in some cases they may not have been successful.

Medical examinations and Intelligence Quotient (IQ) tests

130 Some of the procedures involved at particular stages were introduced at the insistence of the Australian authorities who were dissatisfied with the physical and intellectual standard of many of the children being sent to Australia in the early years. This dissatisfaction can be

117 Day 46, 8 September 2014, p.20.
118 Day 46, 8 September 2014, p.45.

seen in correspondence between the Secretary of the Department of Immigration in Canberra, the Chief Migration Officer in London, and the Under-Secretary for Lands and Immigration in Perth in late 1949 and early 1950. This correspondence set out the reasons for their concern at considerable length, but the flavour of the Australian concerns can be seen from the following extract from a lengthy letter of 6 January 1950 from the Secretary of the Department of Immigration to those officers just described. Referring to tests carried out "at various Catholic Institutions in [Western Australia] on child migrants from the United Kingdom" he continued "...I agree that the situation is very disturbing." Having referred to various explanatory factors that might influence these findings he observed "Nevertheless, the percentage of dull, and borderline defective children shown in the report is too high." The letter continues:

> "It is also to be realised that the children who have been examined arrived in 1947, before the immigration schemes were properly under way and it may be that the supervision over the selection of the children could have been tighter at that time."

He goes on to refer to a discussion of this at the conference of Commonwealth and state ministers held at Canberra on 16 May, 1949, and to a decision of the conference that the Chief Migration Officer in London "was then advised to exercise a careful supervision of the children selected", before saying that he has again asked the Chief Migration Officer "to carefully watch the selection of children and let me have his observations."[119]

131 The Sisters of Nazareth were well aware of these criticisms, as can be seen from the circular letter of 21 March 1952 from the Superior General, which has already been referred to. She said:

> "I am grieved to say that the Australian Department for Emigration has complained about problem children, wet beds and mentally deficients [sic] being sent from Nazareth Houses to Australia, and these children will be returned by the Australian Government to the Houses from which they were sent...The Home Office, London has been notified by the Australian Government about this matter, even the Nazareth Houses in this country that sent such children have been named to the H[ome] O[ffice], so it is humiliating for the

119 NAA A445, 138/2/8.

> Congregation, and looks as if we were putting our obligations on other people. This is very serious, as I have been notified that some Catholic Homes in Australia were to be closed to children on account of the unsatisfactory state of affairs among these children."[120]

132 The manner in which the procedures involved in child migration were applied and developed can be seen by comparing the experiences of HIA 330 and HIA 336. HIA 330 was placed in Nazareth House, Bishop Street, and she remembers very little about her time there. She was one of 54 children from Northern Ireland, and one of twelve girls from Nazareth House, Bishop Street, who sailed on the first sailing of children to Australia from the United Kingdom on 29 August 1947. She was six-years-old at the time and so it is not surprising that she has little recollection of what happened. It appears from the Commonwealth of Australia immigration documents she obtained that she underwent a medical examination by a doctor at Australia House in London, which appears to have been carried out on 16 July 1947. The sponsoring organisation is described as the Catholic Council for Child Welfare of Coleshill, Birmingham, and the certificate relating to her background was signed by SR 139 who was the mother superior of Nazareth House, Bishop Street, at the time. She also signed as the child's guardian on 15 July 1947. Her signature was witnessed by P.A. Conlon, clearly Brother Conlon, who gives his qualification as a migration organiser, and his address as 38 Strawberry Hill, Twickenham. As her ship sailed on 29 August, if the medical examination took place on 16 July in London as the form implies, it would seem that on or about 15 July HIA 330 left Londonderry and travelled to London, presumably spending the time between her medical examination and her sailing on 29 August at a Sisters of Nazareth home somewhere in England.

133 HIA 336 (who was an applicant to the Acknowledgement Forum only), provided the Inquiry with a comprehensive set of papers showing that the process had become considerably more elaborate by 1956. These documents show that his unmarried mother gave her consent to his migration on 28 November 1955. Application forms sent to the Department of Immigration in December 1955 said (a) that he was in care and (b) that the Secretary of State had given his consent to HIA 336's emigration. The Sisters of Nazareth sent a formal application to the Department of Immigration at Australia House in London, which was

120 AUS 5407-08.

received by it on 16 January 1956. He underwent an initial medical examination on 26 February 1956, and was medically examined again on behalf of the Australian Department of Immigration by a Belfast GP, Dr John McSorley on the Ormeau Road, whose report was compiled in or around 10 April 1956. In August 1956 HIA 336 was one of nine children from Nazareth Lodge, Belfast who were then subjected to IQ tests by Prof. Seth, the Head of the Department of Psychology at Queens University, Belfast. Professor Seth sent his results to the Australian Department of Immigration in London.[121] HIA 336 was just six when he sailed from Southampton on 24 December 1956 on the *SS Strathnaver*, arriving in Freemantle on 22 January 1957.

134 In HIA 336's case thirteen months elapsed between his mother giving her consent in November 1955 and his sailing on Christmas Eve 1956, and no doubt the process of identifying him as a possible emigrant child started some time before that. The process from being selected for consideration for emigration until sailing was often a particularly long drawn-out one, in most cases taking several months. Although the manner in which this happened is not clear in every respect, it appears to have been the position that in many, if not all, of the cases where children were sent from one of the four Sisters of Nazareth institutions in Northern Ireland, the mother superior of the house started the process by nominating individual children to one of the Roman Catholic organisations responsible for child migration, such as the Australian Catholic Immigration Committee (ACIC). That would seem to be the position from a letter sent on behalf of the Director of the ACIC to the mother superior of Termonbacca in 1951. He indicated that he already had a list of names on file and suggested four names to the mother superior. He stated that application forms, birth certificate, baptismal certificate, confirmation certificate if confirmed, case history, IQ report and school report were required, saying "many of these documents we have already." He then set out the papers which he held for each of the children, and asked whether or not the children were still available for emigration, together with any other names that might be put forward for inclusion in a later batch. He concluded "We would point out that very careful selection is now taking place and, therefore, if children are anyway below average and do not come up to the required standard, they are being sent back."[122]

121 AUS 11839.
122 AUS 5218.

135 The emphasis placed by the Australian authorities on the need to select children who were in good physical and mental health is clear, and is confirmed by his next letter. As that letter was believed to have been wrongly addressed, a further letter was sent including the name of a fifth boy who was thought to be the brother of one of those mentioned in the earlier letters. It again makes the point about the need for children to reach a certain standard, because the letter concludes "when submitting further applications, Father Nichol asks you to bear in mind the fact that if these children are in any way below average, mentally or physically, they will be sent back..."[123]

136 Only a few applicants have any recollection of being medically examined, or of undergoing IQ tests, before they were sent to Australia. Nine applicants remember undergoing medical examinations, and the immigration documents for many more record medical examinations. Whilst there is documentary evidence of the IQ tests on nine boys in 1956, it is noteworthy that two applicants who sailed on the first sailing on 28 August, 1947 have clear memories of undergoing IQ tests,[124] and HIA 350 (who was seven years and five months old when she sailed) recalls that Br Conlon, a sister and a government official were present. Correspondence from the CCWC to the mother superior of Termonbacca in 1952 requested both school and IQ reports.[125] Given that children in the first and last groups to go to Australia from Sisters of Nazareth homes in Northern Ireland underwent such tests, that there is substantial evidence that the Australian Government placed considerable emphasis on assessing child migrants' intelligence, and that IQ tests were required by children from the state sector as in the case of HIA 354, we are satisfied that IQ tests were conducted on applicants who do not now recall them. We are satisfied that it is highly likely that after 1947 all children went through the required procedures, including medical examinations and IQ tests, and it is not surprising that 50 or 60 years later applicants do not remember some parts of the process, given that the process was often long drawn out, and that many would not have appreciated the significance of what was happening.

123 AUS 5216 and 5217.
124 HIA 299 and HIA 350.
125 AUS 12178.

Were illegitimate children singled out for emigration?

137 A number of applicants expressed the belief that the children selected for emigration were chosen because they had no parents to speak for them, and the implication in those cases is that all or many of the children were selected because they were illegitimate. As we have pointed out, there is evidence that the Sisters tried to contact a parent of a child being considered for emigration, and that in a number of cases where contact was made the parent or relative refused to consent. It also has to be remembered that during the decade in which child emigration took place the proportion of illegitimate children in all children's homes in Northern Ireland was very high, as can be seen from figures gathered in 1957 by the Northern Ireland Child Welfare Council.[126] It found that in the six largest children's homes, two out of every three children were illegitimate. Of the six homes, the percentages were 82.8 % in Nazareth Lodge, Belfast; 62.1% in Nazareth House, Belfast; 57.7% in Nazareth House, Londonderry; and 60% in St Joseph's, Londonderry (Termonbacca).[127] We have no reason to believe that the position was significantly different in the ten years before 1957. A further consideration is that, as the same report pointed out, many parents did not maintain contact with their child once the child was placed in a home. The report gave the following percentages for parents in the four Sisters of Nazareth homes who did not maintain contact with their children: 57.4% in Nazareth Lodge, Belfast; 48.8% in Nazareth House, Belfast; 13% in Nazareth House, Londonderry; and 45.5% in St Joseph's, Londonderry (Termonbacca).[128] With the proportion of illegitimate children so high in each of these homes, it was inevitable that there would be a high proportion of illegitimate children amongst those selected. We note that of the witnesses who contacted the Inquiry, only four were members of families of five or more children.

138 Because the sisters who made these decisions and the parents of the children are dead, and because there are not many contemporary records that throw any light on why an individual child was selected other than the migration forms, there is insufficient evidence to enable the Inquiry to decide in each individual case whether, and if so to what extent, the fact that a child was illegitimate was a factor that led that

126 *Operation of Social Services in relation to Child Welfare*, p.2.
127 Ibid, p.5, para. 11.
128 Ibid, Appendix 13, p.41.

child to be selected for emigration. All that we can say on this issue is that because the percentage of illegitimate children in each of the four homes was so high, and so many parents no longer maintained contact with their children, and therefore could not be asked for their consent to their children being sent to Australia, it was likely that illegitimate children would form a high proportion of the children who were selected.

What were the children told, and were they asked if they wanted to go?

139 Many applicants, but not all, had some recollection of Australia being mentioned to them before they went, although there are considerable variations in their accounts of what was said to them. A very common theme amongst those applicants who could remember being told something was that they were given a wholly misleading picture of the conditions they could expect to find on arrival in Australia. HIA 335 said that Br. Conlon "said we would be able to ride horses and pick oranges off trees."[129] HIA 299, who went to Australia in September 1947 aged ten and a half said:

> "Brother Conlon brought books about Australia and told us it would be good there, the aboriginals were great, there was plenty of orchards and fruit and we would never go hungry...I had no idea where Australia was but I was convinced by his description of the country."[130]

140 HIA 299 described how he helped to build the buildings and clear land when he arrived. Although conditions in Australia are not within our terms of reference, we note that there is ample contemporary evidence that the boys engaged in heavy physical labour helping to construct large buildings at places such as Bindoon. Captions to photographs of Bindoon in the undated pamphlet about the Western Australian institutions already mentioned such as "Administration block in course of construction by boys",[131] and "Boys tiling the Refectory Block",[132] make this very clear.

141 Not all applicants remembered being given any explanation about where they were going, or, if they were told, say they were not told the truth

129 AUS 10957.
130 AUS 10342.
131 AUS 2607.
132 AUS 2610.

about their forthcoming journey. HIA 300, who was eight years old when he went to Australia in August 1947, recalled that the sisters said "all those who want to go to Australia put your hands up. We all put our hands up as it sounded exciting but I had no idea at the time where Australia was, nor did the other boys."[133] HIA 350 remembered doing an IQ test, being patted on the head and told that she was a smart girl and was going on a trip to Australia. "We were given the impression that life was going to be like a fairy tale, with lots of fruit, sunshine and kind people."[134] However, HIA 240 said that a priest told him he was being sent on a three-week holiday to England and instead he was sent to Australia.[135]

142 Australian officials in the United Kingdom were required to interview each child to ask the child whether he or she wanted to go to Australia, but of 28 applicants who were sent by the Sisters of Nazareth, twenty-one said that either they were not asked at all whether they wished to go, or they were simply told that they were going. However, although HIA 299 was one of the twenty-one who were not asked, he remembered Brother Conlon asking the boys in Nazareth Lodge if they wished to go, and seven applicants remembered being asked. Five of them were in Termonbacca, one in Nazareth Lodge, and one in Nazareth House, Belfast. That children from three different homes remember being asked if they wished to go, suggests that each child was asked if he or she wanted to go to Australia. In addition, we were provided with correspondence from January 1951, March 1953 and March 1956 between the Australian emigration authorities and the mother superior of Termonbacca making arrangements for interviews of boys at Termonbacca itself or at the local employment exchange.[136] Given that the majority of the children sent by the Sisters were younger than ten, it is not surprising that many have no recollection of being asked, and we are satisfied that the children in the four Sisters of Nazareth homes with which we are concerned were asked whether they wanted to go to Australia, although it is unclear whether this was always done by Australian officials, by the Sisters or by other Catholic officials such as Br. Conlon.

133 AUS 10377.
134 AUS 11202.
135 AUS 11554.
136 AUS 12099, 12104 and 12108.

143 Whilst many children may have been asked in some form whether they wanted to go to Australia, we accept that they were given an idealized and wholly unrealistic picture of what their lives in Australia would be like. While we accept that there was discussion with the children about going to Australia, we do not accept that the children were in a position to give an informed consent, and we do not accept that asking children of such a young age for their consent had any worthwhile purpose. We have already pointed out that where the consent of the Minister of Home Affairs was required many responsible bodies and senior civil servants expressed the view at the time that no child under the age of ten (or even older in the view of some) could reasonably be expected to understand the implications of what they were being asked. Given that many of the children sent from Northern Ireland were under eight, and some as young as four or five, we are satisfied that the procedure of asking children under fourteen to obtain their informal consent to go was a worthless and wholly indefensible practice, and should have been recognised as such by the Sisters, the Australian Commonwealth and state governments, and the United Kingdom Government.

Travel arrangements for the children

144 There were suggestions that there was a financial incentive for the Sisters to send children to Australia, and that they profited from doing so. For example, HIA 401 said she had seen documents whilst doing some archival work which suggested that the Sisters received either £10 or AUS $10 for each child. This was explored with her when she gave evidence and she said that the Australian Government was "basically helping to finance the child migrants coming to Australia."[137] Sr Brenda explained that the Sisters were reimbursed for the cost of travel and clothing provided to the children for the journey, but the Congregation did not profit by doing so. It is clear that the Australian Government provided travel warrants for the travel costs of the children to the point of embarkation. It also paid the passage fare for the children to Australia. It also appears that, at least in some cases, it reimbursed the Sisters for the cost of providing new clothing for the children they sent. That can be seen from an entry in the Sisters of Nazareth *History of Foundation* for Nazareth Lodge disclosed to the Inquiry during module four. This recorded that on 7 May 1949 the Sisters received a cheque for £55 "from the Australian Migration Scheme towards the outfits of

137 Day 48, 10 September 2014, pp. 19 and 20.

the fourteen boys who went to Australia in August 1947."[138] However, we have found no evidence to suggest that the Sisters of Nazareth profited financially from taking part in the Child Migrant Scheme.

145 The children were provided with new clothes for their journey, and then travelled by train and boat from Northern Ireland to England. Some of those sent by the Sisters seem to have stayed for a short time in one of the Sisters of Nazareth houses in England, others went direct to the port of embarkation where they joined their ship. All children, whether sent by the Sisters of Nazareth, by county welfare committees or by the Irish Church Missions, were accompanied during the voyages by adults assigned to look after them during the voyage. Some were priests, sisters, or Protestant clergy in the case of children going to Dhurringle; others were young women recruited for the purpose who had their fare paid to Australia in return for looking after their charges. Most, though by no means all, of the children had happy memories of the voyage, having ample food and being allowed to go where they wished on the ship. Others, as in the case of HIA 346 and HIA 354, whose experiences we have already recounted at paragraph 95, did not consider they were well looked after on the voyage. Given the post war shortages of food and general austerity in Northern Ireland and the rest of the United Kingdom the conditions on board for many seem to have been a considerable improvement on what the children were used to. However, none of the institutions appear to have paid much attention to checking the suitability of those to whom the children were entrusted to look after them in any structured fashion.

146 Very little information about the children appears to have been sent with them. By 1954 the migration forms required "case histories", but we have found nothing that would suggest that the Sisters in particular provided anything that could be described as a "case history". We consider that even in 1954 good practice would have required a minimum of a half page outlining the nature of the family, its problems and the reason why the child was in care. The absence of such information was unacceptable at the time, and the lack of information undoubtedly also contributed to the difficulties experienced in later years by many former child migrants when they tried to get employment or trace their families. **We regard this failure to be a systemic failing on the part of any institution that sent children and cannot show that such information was sent.**

138 SNB 11638.

Efforts by the British and Northern Ireland Governments to ensure that children were being properly looked after in Australia

147 As mentioned earlier, John Moss CBE was a member of the Curtis Committee, and was the Kent County Welfare Officer. When the Home Office learnt that he was due to make a private visit to Australia in 1951, it asked him to make some enquiries into conditions in those homes where children emigrating from the United Kingdom were received. His report *Child Migration to Australia* was published in 1953 and described by the United Kingdom Government as "an independent record of Mr Moss's impressions, and is not to be taken as expressing the views of the Home Office or of any Australian authority." His report was broadly favourable to the principle of child migration, although he did make comments about a number of individual homes. He also made a significant number of recommendations, which might suggest that although he was broadly satisfied with what he found, nevertheless there was considerable room for improvement. In his conclusions he said:

> "I hope this report will give an impetus to the emigration of children from the United Kingdom to Australia as I have no doubt that many children who are in children's homes here would have much better prospects in Australia if they are carefully selected and are of suitable ages."[139]

Of particular relevance to the work of this Inquiry is that he "formed the opinion that the Roman Catholic establishments for children in Australia compare very favourably with those in this country."

148 It is also significant that whilst he noted that some 2,000 children had been emigrated under this scheme since the end of the Second World War:

> "Local Authorities have taken very little interest in the scheme, either in relation to children in their own children's homes or children for whom they are contributing in voluntary homes such as Roman Catholic orphanages. Local Authorities must naturally be satisfied that any action they take as to children in their care is in the interest of the children. There seems to be a feeling in some quarters that it is wrong to send a child, for whom a Local Authority is responsible, some 10,000 or 12,000 miles away."

139 Page 41.

Moss concluded that if those responsible had the same opportunity as he and his wife had of inspecting these premises:

> "I am sure they would have no hesitation in helping to fill the vacancies which now exist in approved establishments and would adopt a general policy of sending a regular, but small, flow of suitable children. They would then not only be doing good to the children but helping, in a small way, to increase the English-born population of Australia."

He completed his report in January 1952, and it is clear from the Northern Ireland Government file that a copy of this report was received by the Ministry of Home Affairs, as the title page of the report bears a number of hand-written references to the Big Brother entries and those relating to Dhurringle in the report.

149 The Empire Settlement Acts were due to expire in 1957, and as payments were made under the Acts to those voluntary societies concerned with child migration to Australia the United Kingdom Government appointed a fact-finding mission to visit Australia. This was chaired by John Ross CB, a former Under-Secretary of State at the Home Office. He and his colleagues produced their report in March 1956. It was highly critical of the conditions in Australia in many of the institutions, 26 of which were visited by the committee, and the Australian Government would not agree to its publication until its own officials had visited the institutions. The Australian Senate Report noted that shortcomings were only detected at Dhurringle and Bindoon and minor improvements suggested. The Australian Government investigation concluded "in view of [this], it is felt that there is no justification for your [the British] government to take any action, to cause even a temporary deferment of child migration to Australia." In the United Kingdom the Commonwealth Relations Office recorded that "as we feared the Australian authorities focus only on material things like bathrooms and carpets, and ignore what had been said about atmosphere and management." A United Kingdom Home Office official noted that the Australian report "confirms my view that Australian and United Kingdom thinking on childcare matters is poles apart."[140]

150 The Ross Report was extremely critical of the principle of child migration, in particular about matters such as the unsatisfactory premises, the

140 *Senate Report* 2.114.

isolation of the homes, that children were being separated by gender and also that siblings were being separated, and as Ross put it, not all the staff had "sufficient knowledge of childcare methods". In addition to the five institutions which he expressly criticised, he attached to his report a secret annex which was not published. In that, he was very critical of a number of other institutions he had not publicly criticised because he hadn't been to all of them, and the information was not sufficiently strong in some instances to allow him to express public criticism. The Ross report was also made available to the Northern Ireland Government, including its secret annex, and the copy in the Ministry of Home Affairs file carries a manuscript note that it was copied to Miss Forrest, Miss Wright and Miss Miller in February 1957. At this time the Northern Ireland Government anticipated a visit from Australia by a leading public figure there and was somewhat embarrassed by the position in which it found itself. In the event, the last children to be sent by the Sisters of Nazareth had already sailed on 24 December 1957, and so far as the Inquiry is aware no further children were sent from Northern Ireland other than the three children who went from Manor House in Lisburn in 1969. However, as they were older and went at their father's request they do not fall into the category of child migrants with whom we are concerned.

Contact between the homes and child migrants after they went to Australia

151 It is a common complaint by applicants that they received no letters from home, that letters were kept from them if they were sent, and that their parents in many instances either were unaware that their children had been sent to Australia, or maintained subsequently that they had been deceived about that. HIA 392 said that he received some letters from his mother for the first eight months after he went, although these stopped when he asked her why she sent him to Australia.[141] HIA 274 said that her mother managed to trace her to Australia and wrote to her, and although HIA 274 wrote back she doubts whether the letter was ever sent. However, even the minimal contact both experienced was exceptional to judge by the evidence of the great majority of applicants to the Inquiry, only five of whom received letters from parents or other family members after they went to Australia. These are all matters which we have considered in the context of the acts or omissions of those who

141 AUS 11367.

were responsible for these children in Northern Ireland. The efforts of Tyrone County Council in trying to keep in touch with its child migrants demonstrates what could, and we believe should, have been done in this respect by everyone who sent a child who was in their care to be placed in the care of another institution in a country many thousands of miles away. If the Tyrone Welfare Committee could go to such efforts to keep in touch with one child what was to prevent other organisations pursuing the same policy? Although the Sisters of Nazareth may not have the same financial and administrative resources as public bodies, we consider that they could and should have done much more to keep in touch with the children in Australia. The girls went to other homes run by the Sisters, such as Geraldton, and there was nothing to stop the mother house in Hammersmith asking their sister houses in Australia, or the Roman Catholic Orders to which the boys had gone, such as the Sisters of Mercy or the Christian Brothers, for a short report of a few lines on each child once a year, and passing this information to those parents or relatives for whom they had contact details, or who enquired after a child. **We regard the failure of the Sisters to do so as a systemic failing on their part.**

152 The Inquiry has no power to investigate the way these children may have been treated by those responsible on the spot for the Australian institutions to which they were sent after they arrived. Nevertheless, our view is that it is necessary to consider what steps the Sisters of Nazareth took to keep themselves informed about the progress of the children in Australia because the Sisters had sent children in their care to a distant country. In only one case that we are aware of did information come back from Australia to the Sisters in Derry, and through them to those close to the applicant. HIA 342, who sailed in August 1947, said that in later years she learnt from a family with whom she had lived in Derry before going into Nazareth House in Bishop Street that the Sisters in Australia sent back photographs of her growing up. The photographs included photographs of her graduation, although she could not remember graduating.[142] If what she was told is accurate, that would suggest that in her case at least an effort was made by the Sisters in Australia to send back information, but, if so, that would appear to have been an exceptional event. There is no other evidence to suggest that the Sisters in any of the four homes in Northern Ireland made any effort to seek information, or received information, which they

142 AUS 11074, Day 47, 9 September 2014.

passed on to the families concerned about the children sent from their homes. In some cases the children went to homes in Australia run by the Sisters, such as the home for girls at Geraldton in Western Australia, and whilst it is possible that the mother general or her representative may have enquired after such children in the course of visitations to the Australian homes run by the Sisters, if any information was gathered in this way no evidence has been produced to show that it reached any of the four homes in Northern Ireland.

153 Even if the Sisters sought such information, we consider it likely that very little, if any, information was provided, because that appears to have been the experience of other Catholic organisations in the United Kingdom involved with child migration when they tried to obtain information from Australia about the welfare of the children they had sent there. That this was the case can be seen from the following passage in a discussion paper report prepared for the Catholic Children's Society (Westminster) by its director, J. M. Richards in July 1993:

> "Between the start of the migration programme in 1938 up until May 1956, concerns were often expressed about the migration programme within C.C.W.C. and the Church hierarchy but nothing in effect was done about it. In May 1956 in a letter to Canon Flood, R.T. Rainer from Southwark Catholic Children's Society wrote 'I am keenly interested in these problems of supervision of children in Australia, as I made all the arrangements for all our children to emigrate and interviewed all the available parents but so far have not seen one official report about the welfare and progress of the Southwark children'. He goes on to say that without 'positive evidence of its standards and achievements that the local authorities will not be prepared to use the scheme' for the Catholic children it has in care. Further he states, 'there is an opinion in some quarters that we have merely succeeded in transferring children from one institution to another and unfortunately we do not possess any information which suggests the position is in fact satisfactory'. In another letter, he makes clear that Australia and England do not appear to understand each other's conception of child care. By June 1956 Southwark were no longer prepared to send children to Australia until they had details of the welfare and after care of children already out there. Reports from Australia on children that had been sent out there were very brief in content and spasmodic in arriving."[143]

143 AUS 12199.

154 Because only five applicants received letters from parents or other family members after they went to Australia, for virtually every applicant the effect of being sent to Australia as a child migrant was that they were cut off from their families in Northern Ireland. As a result in later years the great majority of applicants had great difficulty in tracing their families; difficulties caused, or exacerbated, in many cases by not being able to obtain their birth certificates. Twenty-six applicants mentioned that they had to get their own birth certificates in later life, and nineteen described how the details were inaccurate. Whilst some errors may have been due to clerical error, in the case of HIA 326 and others names had been changed, apparently on an arbitrary basis, by the Sisters before they went to Australia. It appears that birth certificates may have been sent by the Sisters with each child, at least to judge by the experience of HIA 273 who described envelopes with birth certificates inside being taped inside the lids of their suitcases before they left, and being taken from them on arrival in Australia.[144] As the correspondence already referred to makes clear, birth certificates were sent by the homes when the applications were being made to the Australian authorities in London. It appears that only short form birth certificates were sent, and because such certificates only include the name and date of birth of the child, and does not contain details of the parents and place of birth, this also created great difficulties for child migrants who wanted to trace relations in later years.

155 Many applicants complained that the Sisters were extremely un-cooperative when contacted in later years for information that would help trace their parents and families, although some individual priests were helpful in providing baptismal and other records. This lack of co-operation by the Sisters in different houses, and not just those in Northern Ireland investigated by the Inquiry, caused enormous difficulties, and great distress and unhappiness, for applicants as they tried to trace their families and roots in Northern Ireland or elsewhere.

HIA 312 expressed the feelings of many of those who spoke to the Inquiry when he said:

> "I regret never having the opportunity to meet my birth mother and having no knowledge of my Irish ancestry. I never made any further enquiries about my family. If you've written me off, you've written me off for life."[145]

144 Day 46, 8 September 2014, at p.16.
145 AUS 10631.

156 The practical difficulties experienced by so many applicants who tried to trace their relatives are graphically illustrated by the example of HIA 333 given to us by Dr Margaret Humphreys.[146] He started to search for his mother in the 1950s, but, despite his efforts, had no success. In 1992 he contacted the Child Migrants Trust and it took up the search. In July 1997 Dr Humphreys and HIA 333 visited Nazareth House in Sligo for the first time. The search continued for several years, and, amongst other things, included efforts to exhume the body of a possible relative in California for DNA tests. The search came to an end in 2008 when HIA 333 visited the Nazareth House in Sligo in June and was given a photocopy of a 1937 document which referred to the recommendation of a Catholic curate in Co. Fermanagh. A third visit by Dr Humphreys to the Nazareth House in Sligo in November 2008 resulted in the back of the photocopied document being produced after a three hour delay. On the back was the applicant's mother's address, and within three days that address had been located, only for HIA 333 to learn that his mother had died in 1999. Throughout her life she lived at the same address, and at one stage when she was still alive the search was being carried out half an hour's drive from where she was living. Had that information been produced in 1997 HIA 333 could have been reunited with his mother before she died and many years of fruitless, time-consuming and extremely expensive enquiries could have been avoided.

157 Even when applicants were able to trace their families the result was sometimes disappointing for them. Sadly, there can be no doubt that some parents wanted their child out of their lives as demonstrated by the experience of those applicants who were able to trace their mother in later life, only to find that she did not want to acknowledge that the applicant was their child. In some cases this was because they had married but never told their husband or children that they already had a child, as in the case of HIA 304. Through his wife's efforts he was able to trace his mother, but when he contacted her "…she was pleased to hear from me, but also horrified. She had put a lid on her past and now it was reopened."[147] Although they corresponded by letter, this was only for a couple of months as she was terrified her husband would find out. The experience of HIA 341 was even less satisfactory, as his mother refused all contact other than one long telephone conversation. The

146 Day 43. 1 September, 2014. Pages 152-62 and AUS 6031-35.
147 AUS 10497. Day 4. 2 September, 2014.

mother of HIA 326 tried to persuade her to pretend she was her niece and not her daughter. HIA 326 later traced the man in Northern Ireland she believes to be her father, and spoke to him by telephone. He did not admit he was her father, nor did he respond when she sent photographs of her children.

158 The experience of HIA 333 may be an extreme example, but it illustrates the great difficulty experienced by many applicants in obtaining basic information about the past from the Sisters of Nazareth. These difficulties could have been avoided in many cases had the Sisters been more forthcoming when applicants approached them for information. Whilst we recognise that in some cases information was forthcoming, in too many cases it was not produced as willingly or rapidly as it should have been. **Although in some instances the Sisters may have felt that withholding such information might prevent further distress or rejection, nevertheless we regard the failure of the Sisters to provide detailed, accurate and timely responses to enquiries by child migrants for help in tracing their parents as a systemic failing on the part of the Congregation, and one that added a great deal of avoidable suffering to many applicants.**

159 These difficulties still continue for many applicants, and the Child Migrants Trust informed us on 4 November 2014 that it was working with nineteen former child migrants who have unresolved and complex family research relating to Northern Ireland, although some of these may relate to former child migrants from Great Britain whose parents originated in Northern Ireland. Many applicants spoke in glowing terms of the effectiveness of the efforts of the Child Migrants Trust in helping them to trace their relatives. The continuing need to search for documentary evidence to enable former child migrants to trace their relatives is an acute problem for a number of individuals. A suggestion made to us was that the institutions concerned should be placed under an obligation to bring together all the papers relevant to such individuals in a central location where they could be conveniently accessed by the individuals concerned, or by organisations acting on their behalf, such as the Child Migrants Trust. Whilst this suggestion is attractive, we are concerned it could prove difficult to achieve in practice. It would require a central location to be identified and then funded, although if such a location was considered desirable it might be possible to make an arrangement with the Public Record Office for Northern Ireland to store

records there. However, there would remain the risk that documents might not be accurately identified by institutions which hold them, or may be mislaid whilst being assembled.

160 Perhaps the most compelling objection is the difficulty in defining what documents should be brought together in this way, because birth or baptismal records, school records, social services and national insurance records, to name just a few, might be helpful in tracing relatives, depending upon the information already available. On balance, we consider that a more effective course would be for the Northern Ireland Executive to provide adequate funding to the Child Migrants Trust to enable it to continue its valuable work. It has developed invaluable expertise in carrying out such searches, and enjoys the confidence of those who rely upon it to help them trace their relatives. Rather than creating a new body to do the work already being done by the Child Migrants Trust we recommend that it be given an annual grant for up to ten years, with a review of the effectiveness of, and continuing need for, such work after the first five years. The amount of the grant would be for the Northern Ireland Executive to agree with the Child Migrants Trust.

How many child migrants were sent to Australia from Northern Ireland?

161 Whilst it is impossible for the Inquiry to be certain, we are satisfied that at least 138 children under the age of fourteen were sent to Australia as child migrants within the period covered by our Terms of Reference: of these, 121 were sent by the Sisters of Nazareth; ten by various local authorities; and seven by the Irish Church Missions. If the Sisters of Nazareth sent 127, then the overall number was at least 144.

162 We accept that institutions, local authorities and the Northern Ireland Government believed at the time that it was in the interests of the children to go to Australia, where it was thought that the children would have a much better future than they could expect in Northern Ireland. It is essential to remember that in the decade after the Second World War there were serious economic problems throughout the United Kingdom, such as rationing and shortages of materials to rebuild damaged buildings and factories, at the same time as the need to rectify the pre-war conditions of slums, widespread unemployment and poverty that had existed in Northern Ireland for decades. In such circumstances it is not surprising that those who had immediate responsibility for children

in their care were attracted by the prospects of a better life for those children in a developing country, prospects encouraged by the pleas from the Australian authorities; pleas that gained added weight in the case of the Sisters of Nazareth because they were also made by their co-religionists in Australia.

163 Nevertheless the manner in which the child migration schemes were conceived, planned and implemented was gravely defective. The lessons of the problems associated with earlier child migrant schemes to Canada, and the concerns of many professionals in the childcare field, were ignored. Those responsible for the homes were content to rely on unrealistic assurances about the conditions in the homes to which the children were to go. Had they checked beforehand they would have found that in some cases the buildings were still in the course of construction, and that the children were expected to work as labourers to an extent that would have been prohibited on building sites in the United Kingdom. Neither the homes nor the children were given realistic information about the conditions that would face them when they arrived in Australia. The great majority of the children were far too young to make an informed choice if they were asked. They were being sent many thousands of miles away without any preparation for their new life.

164 Had these children, and particularly those from homes run by the Sisters of Nazareth, remained in Northern Ireland they would not have experienced the harm caused to them by child migration. In almost every case nothing was done by the institutions to maintain links between the children and their families in Northern Ireland after they had gone. In many cases when relatives did enquire about the children they were deliberately misled. In later years when former migrants contacted institutions seeking information that might enable them to trace their families all too often the institutions concerned did little to help, particularly in the case of the Sisters of Nazareth.

165 The first recognition by the UK Government that child migrants had been badly treated came in the establishment of an inquiry set up by the House of Commons Select Committee on Health in 1997. It gathered evidence not only in the UK but also through a visit to Australia where former child migrants presented their case to the parliamentary delegation forcefully. The outcome was a report entitled *The Welfare of Former British Child Migrants* published in July 1998 (CM 4182).

166 Among its seventeen recommendations, nearly all of which were accepted by the Government, it argued for a central database to help former child migrants access material to help them trace their families. It proposed the establishment of a travel fund so that former migrants could make links with their families, and the government set up a £1 million fund. The Select Committee had highlighted the invaluable work being done by the Child Migrants Trust and the government increased funding for the CMT to £500,000 over three years.

167 The Select Committee did not recommend that compensation should be paid to former child migrants as they had received markedly differing evidence, and many people had expressed concern that agencies might be less cooperative in providing records if they became unduly nervous about possible financial consequences; the government concurred. The Select Committee had also received differing evidence on the value of an apology; while they felt that an apology was in order, they argued that action on their recommendations would be the best acknowledgement of concern on the part of the government, who responded by expressing regrets and accepting that they considered that the child migration policies had been misguided.

Steps taken by the United Kingdom Government and the institutions to address the effects of the child migrant scheme

168 In recent years in different ways both the British Government and the Sisters of Nazareth have acknowledged the grave injustice done to child migrants from the United Kingdom, apologised to them, and provided practical financial support to some of those who are still alive. On 24 February, 2010 the Prime Minster, the Rt Hon Gordon Brown MP, made the following statement to the House of Commons:

> "Until the late 1960s, successive UK Governments had over a long period of time supported child migration schemes. They involved children as young as three being transported from Britain to Australia, Canada, New Zealand, South Africa and Zimbabwe. The hope was that those children, who were aged between three and fourteen, would have the chance to forge a better life overseas, but the schemes proved to be misguided. In too many cases, vulnerable children suffered unrelenting hardship and their families left behind were devastated. They were sent mostly without the consent of their

mother or father. They were cruelly lied to and told that they were orphans and that their parents were dead, when in fact they were still alive. Some were separated from their brothers and sisters, never to see one another again. Names and birthdays were deliberately changed so that it would be impossible for families to reunite. Many parents did not know that their children had been sent out of this country.

The former child migrants say they feel that this practice was less transportation and more deportation - a deportation of innocent young lives. When they arrived overseas, all alone in the world, many of our most vulnerable children endured the harshest of conditions, neglect and abuse in the often cold and brutal institutions that received them. Those children were robbed of their childhood, the most precious years of their life. As people know, the pain of a lost childhood can last a lifetime. Some still bear the marks of abuse; all still live with the consequences of rejection. Their wounds will never fully heal, and for too long the survivors have been all but ignored.

When I was first made aware of this wholly unacceptable practice, I wrote to the Prime Minister of Australia to urge that together, we do more to acknowledge the experiences of former child migrants and see what we could achieve. It is right that today we recognise the human cost associated with this shameful episode of history and this failure in the first duty of a nation, which is to protect its children.

Shortly, I shall be meeting a number of former child migrants here in the Palace of Westminster to listen first-hand to their experiences, and as Prime Minister, I will be apologising on behalf of our nation. To all those former child migrants and their families, to those here with us today and those across the world - to each and every one - I say today that we are truly sorry. They were let down. We are sorry that they were allowed to be sent away at the time they were most vulnerable. We are sorry that instead of caring for them, this country turned its back, and we are sorry that the voices of these children were not always heard and their cries for help not always heeded. We are sorry that it has taken so long for this important day to come, and for the full and unconditional apology that is justly deserved to be given.

I would like to recognise the work of my right hon. Friend the Member for Rother Valley (Mr. Barron) as Chairman of the Select Committee

> on Health, and of his predecessor the former Member for Wakefield, David Hinchcliffe. For their commitment to this cause, I would also like to praise all past and present members of the Commons Health Committee and the all-party group on child migrants. I would also like to pay tribute to the work of the Child Migrants Trust and the International Association of Former Child Migrants and their Families, which have campaigned for justice over many years. I know that the House will join me in paying special tribute to Margaret Humphreys, who founded the Child Migrants Trust and has been a constant champion and fighter for child migrants and their families.
>
> Although we cannot undo the events of the past, we can take action now to support people to regain their true identities and reunite with their families and loved ones, and to go some way to repair the damage that has been inflicted. I can announce today support for former child migrants that includes the establishment of a new £6 million family restoration fund.
>
> There are many painful memories as a result of the child migration schemes, and for many, today's apology will come too late for them to hear it. We cannot change history, but I believe that by confronting the failings of the past we show that we are determined to do all we can to heal the wounds. I commend this statement to the House."[148]

169 A number of applicants to the Inquiry were present when this statement was made, and in their evidence to this Inquiry they and others welcomed the apology. The Family Restoration Fund referred to by the Prime Minister provides financial assistance to former child migrants by paying for flights to, and accommodation in, the United Kingdom by former child migrants who want to re-establish links with their families and relations. A significant number of applicants have taken advantage of the Fund to return to the United Kingdom for two-week visits, and it is apparent that they have greatly appreciated this practical assistance to enable them to meet their families. During the Inquiry it emerged that HIA 401 wrote to the Secretary of State for Health pointing out the difficulties created by the three-year limit on the life of the Fund. The Inquiry asked that the position be clarified, and was informed by counsel for the DHSSPS that it has been confirmed that the life of the Fund will be extended until 2017.[149] Whilst the Family Restoration Fund has undoubtedly been of

148 Hansard Debates (House of Commons), 24 February 2010.
149 Day 50, 15 September 2014 at p.28.

considerable assistance to many former child migrants, it will therefore expire in 2017 unless the United Kingdom decides to further extend its operation.

170 In recent years the Sisters of Nazareth have supported about 50 former child migrants in a similar way by paying for their flights back to the United Kingdom.[150] The Sisters have also apologised to those children in their care who were sent to Australia from the Sisters' homes in Northern Ireland. In 2005 they issued a statement in which they said:

> "We, the Sisters of Nazareth, sincerely apologise and are deeply saddened by the pain and distress suffered by so many men and women as a result of the Child Migration Scheme. We wholeheartedly commit ourselves to continue to support those who contact us and warmly welcome each one to Nazareth House, welcoming accommodation if required."[151]

171 At the conclusion of her evidence to the Inquiry on behalf of the Sisters, Sr Brenda said:

> "I think hindsight's a great thing and I think – looking back now, I think the Congegation regrets the grave injustice done to these children in sending them out, not just to the children but to their families as well, and I think no matter the most eloquent apology, or the most beautiful monument, or no matter how much money they receive will never make up for what we took from them in sending them there. I know some made good lives for themselves, and having been out in Australia and spoken to some migrant children, they still have this, 'What if...? What if I had stayed in Ireland?' even though they had made good lives for themselves out there, and I think we have to acknowledge – that's the government, the British Government, the Australian Government, the churches, the congregations, the institutes – we all have to put our hands up and acknowledge that maybe it wasn't the right thing, even though it was done in the best interests of the child at the time."[152]

150 Day 49, 11 September 2104 at p.50.
151 AUS 8190.
152 Day 49, 11 September 2014, pp. 45- 46.

Systemic Failings by the Northern Ireland Government

172 **(1) It was indifferent to the practice of the voluntary sector in Northern Ireland of sending child migrants to Australia.**

(2) It failed to fully inform itself as to what was happening once it became aware that significant numbers of such young children were being sent to Australia by voluntary organisations such as the Sisters of Nazareth.

(3) It failed to make any enquiries whatever as to the fate of these children.

(4) It failed to make any representations to the United Kingdom Government about the operation of the child migrant schemes.

(5) Because HIA 354 was so young, the Minister of home affairs was wrong to approve the proposal by Tyrone County Welfare Committee that HIA 354 should be sent to Australia.

Systemic failings by Tyrone County Welfare Committee

173 **(1) It was wrong to send HIA 354 to Australia, because he was so young.**

(2) It failed to give proper weight to the effect of severing contact between HIA 354 and his brother and sister when seeking approval from the Minister.

(3) It failed to inform the Minister that HIA 354 had a brother and sister who were also in the care of the Committee.

(4) It failed to inform the Minister that the foster parents of HIA 354 wished to adopt him.

Systemic failings by the Irish Church Missions and Manor House Home

174 **(1) The home was wrong to send children to Australia who were so young.**

(2) The home failed to take sufficient steps to maintain contact with the children after they went to Australia.

(3) The home did not give truthful information to parents of the children who enquired where their child was.

Systemic failings by the Sisters of Nazareth

175 **(1) They were wrong to send children to Australia who were so young.**

(2) They failed to make any enquiries to satisfy themselves that the homes run by other Roman Catholic religious orders in Australia were suitable to receive their children.

(3) They failed to take sufficient steps to maintain contact with the children after they went to Australia.

(4) They did not give truthful information to parents of the children who enquired where their child was.

(5) In many cases they did not provide detailed, accurate and timely responses to enquiries by former child migrants for information that would have assisted them to trace their parents and relatives.

Systemic failings by all those institutions who sent children to Australia

176 **(1) Failing to ensure that those who accompanied the children were competent to look after the children during the voyage.**

(2) Failing to ensure that a suitable case history was sent with each child to the institution to which the child was being sent.

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Module 4 – Sisters of Nazareth, Belfast: Introduction

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Introduction

1 In Module 4 we considered two Roman Catholic children's homes, Nazareth House and Nazareth Lodge, which were sited near each other, about one and a half miles south of Belfast city centre. The Module commenced with an introduction by Senior Counsel on 5 January 2015, and continued until 19 May 2015 when there were closing submissions. In all, there were 41 days of hearings allocated to this Module. In total, evidence was received concerning the two homes, either in person or through the reading of their statements, from a total of 117 witnesses who had been in Nazareth House or Nazareth Lodge as children. Of these, (taking account of witnesses who were in both homes) 74 gave oral evidence in this module. Thirty-three other witnesses, such as sisters, houseparents, social workers or inspectors also gave oral evidence. More people spoke to the Inquiry about the Belfast Nazareth homes, therefore, than about any other homes.

2 There were 50 applicants who had been resident in Nazareth House who contributed statements. The evidence of ten of these witnesses was read out as they were unable to attend for health reasons, and two because the witnesses sadly had died since preparing their statements. Three did not engage further with the Inquiry. One witness had given his evidence about Nazareth House during the module on Rubane. We therefore heard oral evidence from 34 witnesses.

3 We received evidence from 52 former residents of Nazareth Lodge. The statements of five were read out because of the ill health of the applicants, and two because of the deaths of the applicants, again sadly before they could give oral evidence. Five of the witnesses had given their evidence in the Rubane module, so that in this module we received oral evidence from 40 witnesses. In all, 31 of the people who gave evidence to the Inquiry concerning the Belfast Nazareth homes had also been in Rubane, as from 1953 to 1972 the boys in Nazareth Lodge were usually transferred there at the age of eleven. Two of the witnesses were not applicants but were former residents, one of them appearing at the request of the Sisters of Nazareth.

4 A number of children were sent to Australia as child migrants from both homes. Of these, two former residents from Nazareth House and one from Nazareth Lodge gave oral evidence during the module, and have been included in the figures above. There were also ten more applicants

from Nazareth House and twelve from Nazareth Lodge who gave evidence during the module concerning Australia. Their evidence is dealt with in Chapter 6. One of these witnesses had been in both homes, and so in total, therefore, 24 child migrants who had been in Nazareth House or Nazareth Lodge gave evidence to the Inquiry. It should be noted that many applicants who gave evidence in other modules provided only limited accounts of their time at Nazareth House or Nazareth Lodge.

5 We received evidence from seven social workers, six middle and senior managers in the social services and five members of the Social Work Advisory Group (SWAG) or Social Services inspectorate (SSI). One teacher, one GP, one chaplain, one handyman, two volunteers, five houseparents and eight sisters provided evidence. Three of these people did not appear due to ill-health; the remainder gave both written and oral evidence. The evidence of all but one related to Nazareth Lodge, mainly because Nazareth House closed in 1984 and they provided evidence concerning enquiries into complaints about Nazareth Lodge in the following years. In addition, one sister who gave evidence had moved from one home to the other, and her evidence related to both homes.

6 Submissions were also received from Sister Brenda McCall on behalf of the Sisters of Nazareth, from the HSCB on behalf of the predecessor bodies which had provided social work support for the children and their families, and from Dr Hilary Harrison for the then Department of Health, Social Services and Public Safety.

7 We are indebted to the witnesses, all of whom came to address disturbing and painful personal memories or difficult issues for which their organisations had been responsible. The memories recounted to us typically related to events between forty and eighty years ago, and we have been aware that while the details of some incidents have remained sharp because of their emotional impact at the time, other memories are hazier or may have been influenced by the sharing of accounts or the passage of time. We are aware that for a small number of applicants who came to tell us of their experiences there has been the added shock that other witnesses have accused them of bullying or some form of abuse, and coming to terms with the perceptions of others will have added to their distress.[1]

1 SNB 100007.

8 The Congregation has emphasised the risk entailed in relying on memories that may be faulty or false. We have been alert to the need to cross-check witnesses' written and oral evidence for consistency with the evidence of others and surviving documentation. As might be expected, we have come across errors and inconsistencies. One witness, for example, thought that as a very young child she had been in Nazareth House, but written records indicated that she had confused the home with another institution; in view of her age at the time and the length of time since her period in care, such confusion is thoroughly understandable. The fact that we have quoted witnesses extensively does not mean that we have accepted their versions of events unquestioningly. We appreciate that some evidence will have been affected by exaggeration or false memories, and the fact that we have not qualified every statement with a clause to state that this is the witness's allegation should not be taken to imply that we accept or reject the particular observation.

9 However, the more witnesses who repeated similar accounts of life in the two homes, and the more substantiating detail they provided, the more persuasive they proved to be. It is not our role to decide precisely what happened in relation to each allegation or to determine the guilt of individuals, but to conclude whether on balance there were general systemic failures. The volume and detail of the evidence has been sufficient to provide us with a full picture of what life was like in the two homes and to reach conclusions about the allegations of systemic abuse. It should be noted that, while many witnesses have been quoted in this chapter, on most subjects there were many others who have not been quoted but who provided corroborative evidence.

10 Inevitably, the applicants to the Inquiry have largely been people who had unhappy experiences about which they wished to complain, and drawing together their evidence in this chapter has also been a selective process, primarily identifying the failings of the homes. The picture painted, therefore, is inevitably not a balanced account of life in the homes.

The Homes

11 When the land was acquired and the homes were built, they were in countryside on the edge of the city. Since then, because of urban growth, the sites became embedded in a built-up area, but at the time of their construction the two homes were ideally situated in accordance with the thinking of the time, as they were readily accessible to Belfast, but the

children were able to enjoy the space of the countryside, away from the cramped and squalid city conditions where many of them had previously lived.

12 Both homes were run by the Sisters of Nazareth, and each had its Mother Superior. Both were accountable through the Mother Regional, who was responsible for the Order's services throughout Northern Ireland and the Republic for most of the period covered by the Inquiry to the Mother General, who was based in Hammersmith. The Order, its Rules and its systems of finance, governance and quality assurance are described more fully in Chapter 5 of this Report on Termonbacca and Nazareth House, Bishop Street, which were also run by the Sisters of Nazareth in Londonderry.

13 Although the two homes were sited only two hundred yards apart, they were managed separately, and each had its own community of sisters. For most of their history the main distinction between the two homes was that Nazareth House was for girls while Nazareth Lodge was for boys. Their backgrounds were, however, also distinct, as Nazareth House was a children's home from the start, whereas Nazareth Lodge was originally an industrial school. Until Nazareth Lodge was reclassified as a children's home in 1950, they worked under different regulations and were subject to different systems of inspection.

14 It was the practice in homes run by the Sisters of Nazareth to divide up children by gender and age. This may simply have been a matter of convenience, in view of the need to cope with large numbers of children whose needs did indeed differ with age and gender. Within Nazareth Lodge and Nazareth House not only were the children separated out by gender, but they were also divided by age group. There was a nursery unit for babies and toddlers and separate groups for young children of primary school age and older children of secondary school age.

15 Until families became smaller in the 1970s it was quite possible that the Sisters would be asked to admit several children from one family at the same time, following family breakdown caused by the death of a parent, severe illness or absence through working in England. In consequence, when groups of siblings were admitted, it was possible that they would be placed in different homes and different units within the homes, such that they had very little contact. Children were often unaware of the whereabouts of their siblings, even when they were living in the same

building, and witnesses provided many examples of separation from their siblings.[2]

16 Although this practice of dividing and managing children may have been necessary as a way of supervising large numbers in the early history of the homes, it was considered contrary to good practice throughout most of the period covered by the remit of the Inquiry, as the Home Office Guidance circulated in 1952 made clear.[3] Some witnesses were of the opinion that there was a deliberate policy to split siblings, but it seems that the splitting was essentially the consequence of the way in which the homes were organised, though the impact proved to be sufficient to damage long-term relationships between brothers and sisters.

17 The Congregation was clear that it had no such policy. They denied that there was any attempt to conceal siblings from each other, but admitted that they themselves might have been unaware of siblings placed in other homes.[4] Nor was there any attempt to separate siblings, though the age-based organisation of the homes meant that they might meet infrequently.[5] In their final statement the Sisters said:

> "For the avoidance of doubt, the Congregation maintains that throughout the relevant period it encouraged family and sibling contact wherever it was possible and practical."[6]

Indeed, in their final statement the Congregation gave several examples of families maintaining contact.[7]

18 The splitting of families is a practice that appears to have changed from 1968 onwards, when boys were first admitted to Nazareth House. Almost all of the concerns about the splitting of families were expressed by witnesses who were in the homes prior to 1968 and the witnesses who reported ongoing contact with siblings were in the homes from 1968 onwards.

19 In their later years, the Sisters acknowledged that separating siblings was no longer acceptable and both homes admitted both boys and girls. The Hughes inquiry was informed that the first girls were admitted to Nazareth

2 For examples of children unaware of their siblings, see HIA 91 (SNB 198), HIA 387, HIA 171, HIA 43, HIA 214 (Day 86, p.4) and HIA 152 (SNB 2017).
3 HIA 470.
4 SNB 1508.
5 SNB 1509.
6 SNB 100156.
7 SNB 100153-100165.

Lodge in 1967,[8] but HIA 423 was admitted to Nazareth Lodge as a baby in 1964 so that she could remain with her older brother, with the intention that they would be fostered together. In the event, HIA 423 was six years old before this happened.[9] In 1969, on the direction of a judge, HIA 175's little brother was the first boy to be placed in Nazareth House and he was given the bed next to hers so that she could keep an eye on him.[10]

20 Although the two homes were sited near each other, they do not appear to have interacted much. The Nazareth Lodge boys played football on the playing fields adjacent to Nazareth House, and on occasion the nuns organised visits for girls to go and meet their brothers. HIA 204 only remembered seeing his sisters in the summertime when they played on a field in front of Nazareth Lodge.[11]

21 The children also mingled when invited to Christmas parties provided by Belfast businesses. At times in the 1970s, boys visited Nazareth House to act as altar boys but they recalled that they had no contact with the girls on such occasions. In the later years there were a few examples of children being transferred from one home to the other. There were also a few staff who worked in both homes. By and large, however, the homes were run quite independently as two separate communities.

22 Although the two homes were separately run, there were many parallels in their styles of management, the childcare methods employed and the types of abuse which former residents have alleged. It will be noted that similar patterns could be seen in the two homes run by the Order in Londonderry considered in Chapter 5. While some of these similarities may in part have developed because of the policies of the Order of the Sisters of Nazareth, it seems more likely that they resulted mainly from contacts between people working in Roman Catholic homes sharing ideas on the grapevine, as similar systems and problems have also been reported in other homes, not only run by the Sisters of Nazareth in Northern Ireland, but also by other Orders, and in the Republic of Ireland and in Australia.[12]

23 Nazareth House and Nazareth Lodge are dealt with in separate chapters below, but the similarities mean that there will be some repetition of the key issues, and the headings and subheadings within the two chapters are almost identical. Both homes were very large and institutional. Both were

8 SNB 50092.
9 SNB 5706.
10 SNB 161.
11 SNB 306.
12 Many of the childcare practices reported by witnesses in this chapter are also described in a book about St Joseph's Industrial School at Cavan in the Republic of Ireland where there was a serious fire in 1943.Children of the Poor Clares by Mavis Arnold and Heather Laskey (1985).

seriously underfunded in the early decades of the Inquiry's remit, and this was particularly apparent in the poor levels of staffing, which inevitably led to a dearth of personal individual attention and care for many of the children. Unsurprisingly, a number of impersonal institutional systems were adopted in order to keep the homes going.

24 Over the main decades covered by the allegations (the 1950s, 1960s and 1970s) a variety of improvements were made in both homes, with the introduction of smaller units, the appointment of lay staff to augment the nuns, better living conditions and investment in training for staff. By the end of the period covered by the Inquiry the quality of childcare in both homes had greatly improved, but the use of the homes by the Boards was reduced for a variety of reasons, such as better preventative work, an increased use of foster care, shorter periods in residential care, alternative residential provision and smaller families. In consequence this meant that in the 1980s and 1990s the occupancy of the two homes was steadily reduced and both were eventually closed as they were not economically viable - Nazareth House in 1984 and Nazareth Lodge in 1999.

25 Unhappily, despite the progressive improvements, for a variety of reasons many of these developments appear to have been implemented one or two decades too late. The Home Office Guidance on the division of large homes into small groups issued in 1952, for example, did not become reality until about 1970 in Nazareth House and 1972 in Nazareth Lodge. The care methods being employed by the Order were therefore out of date throughout most of the Inquiry's remit.

26 The failure to update the childcare practice in the two homes appears to have been influenced by two main factors. First, following the implementation of the Children Act 1950, which permitted the welfare authorities to finance the care of children in homes run by voluntary organisations, the state was content to allow the Sisters to continue to proceed as before, relying solely on the funds they could raise from the Catholic community to cover their running costs, though the MoHA helped with capital grants and money to support training programmes. It was only in the 1960s that the welfare authorities took significant steps to take children in the two Catholic homes into care and therefore pay for the care of the children. Thereafter the two homes had increasing levels of income and were able to recruit more staff and to make improvements to the buildings.

27 The second factor is that the Order wished to be self-sufficient and feared the impact of state intervention. It was felt that the appointment of lay staff could have an effect on the values which the Sisters wished to promulgate in the way that they worked with children, and that if they came to rely upon finance from the state, they risked becoming beholden to it. These fears had some grounding. The nature of the care offered did change with the appointment of lay staff, which coincided with a reduction in the number of sisters available to do the work. More significantly, when the Health and Social Services Boards were funding every child and the demand for residential childcare places diminished, the two homes were no longer independent of the state but inevitably had to be reduced in size and eventually closed.

28 It was against this background that witnesses have alleged abuse. It has to be acknowledged that in both homes the sisters responsible for the children must have been under severe pressure, especially in the earlier years, in having to provide for the children's material needs, keep up standards of hygiene and maintain order, day in day out, with few holidays or days off. (The summer period when many of the children were placed with families appears to have been the one time when the Sisters could hold retreats or take time off.) Because of the poor staffing and the pressure on the sisters' time, however, very few children could have experienced personal attention for more than a few moments in the early decades, contrasting sharply with the guidance given in 1970 in the standard text book *Residential Life with Children* that each child should have an hour's individual attention each day.

29 The evidence suggests that in both homes the sisters and other staff fell into three groups.

(a) Despite the pressures, some nuns still managed to remain caring and imaginative in trying to provide homely personal care, and witnesses have spoken warmly about the care they offered, and have maintained links subsequently.

(b) A number of nuns and lay staff are the subjects of small numbers of allegations of abuse, while also being found to be generally supportive and caring by witnesses.

(c) At the core of the witnesses' statements, though, there were in each home a very small number of sisters and lay staff who were the subject of multiple allegations. It was during their tenure that the greatest numbers of allegations of physical and emotional abuse were made.

The sheer volume and detail of the allegations is persuasive, and the difficult conditions under which these staff worked did not offer an excuse for the persistent physical abuse, at times amounting to cruelty, which they inflicted. The accounts given of the abuse meted out by these people will be dealt with individually.

30 In both Nazareth Lodge and Nazareth House there were some children who clearly had miserable childhoods, experiencing a very basic standard of living, receiving no individualised love and attention, and wondering when they were next going to be subject to abuse. It must be stated, though, that other children clearly managed to avoid being abused or positively enjoyed their time in the homes, and many have kept contact with the sisters and lay staff up to the present day. Even some who stated that they were abused stayed in contact because the nuns were the only family they had. Similarly, some witnesses have clearly had most unhappy experiences as adults, probably influenced at least in part by their treatment in the homes as children, while others have had happier lives as adults and have come to terms with their childhood experiences.

31 Although we heard from 118 witnesses in this module, they were only a small proportion of the total number of children - approximately 6,000 - who lived in the two homes. It is impossible to obtain an accurate picture of the experiences of those who did not come forward. We have heard of some who clearly suffered from ill-health and mental health problems, and from anecdotal evidence more ex-residents appear to have died prematurely than one would expect in the population as a whole. We have heard of others who have succeeded in life. Our remit, though, is to respond to the people who came forward as witnesses and to determine from their evidence whether there was systemic abuse.

The History of Nazareth House and Nazareth Lodge

32 The development of Nazareth House and Nazareth Lodge was motivated by the drive on the part of the Roman Catholic Church to provide services for Catholic children, so that they would not need to be admitted to workhouses, state institutions or homes run by non-Catholic organisations where the Church felt that their spiritual needs might not be met appropriately. This was a matter of considerable concern to the Roman Catholic Church in the late nineteenth and early twentieth centuries, as there was some active proselytisation to attract children to become Protestants. The concern continued to influence thinking concerning childcare services within the

Roman Catholic Church up to the 1970s. As Sr Brenda explained, there is now no such concern, and it is the responsibility of those who manage children's homes to ensure that children have opportunities to practise their faith.[13]

33 In 1868 The Industrial Schools (Ireland) Act provided for setting up Industrial Schools for "neglected, orphaned or abandoned children", and "for the rescue and care of younger boys ... who were in danger of becoming delinquent". It was, however, over thirty years before a Catholic home was set up in Belfast to meet this specific need.

34 On 9 May 1876 Bishop Dorrian invited the Sisters of Nazareth to establish an old people's home and to care for children in Belfast, initially in the Bishop's own house in Ballynafeigh on the Ormeau Road. It consisted of two semi-detached villas, which were merged into one to form the home and later incorporated into the main home.[14] Mother St Basil, who was the founder of the Congregation of the Poor Sisters of Nazareth, and three other sisters established the home.[15]

35 in 1877 a number of whitewashed cottages sited on the same property were used for Nazareth House.[16] In 1884 the Sisters of Nazareth had a new building on a site adjacent to the Bishop's house on the Ormeau Road in Belfast.[17] In 1897 a site formerly known as Fox Lodge (which had been used as an industrial school for Protestant boys) was purchased by the Sisters of Nazareth to provide accommodation for 50 boys in Belfast; until then they had lived in a wing of the home for old people.[18] At first, five or six sisters were seconded from Nazareth House to run the home, but it was on 8 August 1900 that Nazareth Lodge, Belfast, was opened for boys by the Sisters of Nazareth as a separate community, and it was registered as an industrial school on 11 November 1902 to accommodate 50 Catholic boys under the age of ten.[19] The girls remained at Nazareth House, and from this time onwards the sexes were segregated for nearly seventy years.

13 Day 119, pp. 85-86.
14 SNB 10010.
15 SNB 10014.
16 SNB 10010.
17 SNB 10015.
18 SNB 10011.
19 SNB 10011,10525,10526,11559.

36 The demand for places was considerable, and as Nazareth Lodge was inadequate for the 200 boys living there, an additional wing was erected, and on 15 October 1905 it was opened by Cardinal Logue. The new building was financed by a loan from the National Bank of £10,000. It is clear that the then Mother General did not approve of the new building or the certification, which had been undertaken at the behest of the Diocese.[20] The Industrial School Certificate was extended in April 1912.[21] The home then served as an industrial school for boys until 1951.

37 The first baby was admitted to Nazareth Lodge on 16 October 1934, when the home took on the role of providing a diocesan service for babies. A purpose-built nursery named Bethlehem was later erected, serving up to 90 babies. Although this was staffed and run by the Sisters of Nazareth and was within the curtilage of Nazareth Lodge, it was technically under diocesan control.

38 The city of Belfast was subjected to severe bombing in April and May 1941. The boys in the upper floors of Nazareth Lodge could see the impact on the city. They were moved to lower floors as a safety measure, but the homes were not evacuated, and fortunately neither home suffered any damage.

39 Overcrowding appears to have been an ongoing problem as the Sisters did not want to turn any child away, but this had a serious impact on the quality of care which could be offered. On 23 December 1949, for example, Nazareth Lodge Industrial School was inspected. It was certified for 206 children, but it was seriously overcrowded and 282 boys were present. There were many detailed criticisms: for example, there were only four toilets for 164 boys aged over 5 years and their accommodation was badly lit and badly ventilated. As a result of the Children and Young Persons Act (Northern Ireland) 1950, reformatories and industrial schools became training schools and an inspectorate was set up. However, very few of the boys at Nazareth Lodge had been committed by the courts: by December 1950 there were only three boys committed by the courts and 274 voluntary cases in Nazareth Lodge.[22] Indeed, all of the applicants from the period when Nazareth Lodge was an industrial school were there on a voluntary basis.[23] It was decided therefore in 1951 that it should be registered as a children's home.

20 SNB 11563.
21 SNB 11573,10525,10526,11559.
22 SNB 13672.
23 SNB 100196.

40 The next major change in the role of Nazareth Lodge was in 1953. Rubane House at Kircubbin was opened, with a Board of Management appointed by the Diocese of Down and Connor, to be run by brothers of the De La Salle Order, to provide for older Roman Catholic boys, and to reduce the overcrowding at Nazareth Lodge.[24]

41 For several years thereafter, parties of a dozen or so eleven-year-old boys were transferred to Rubane every autumn, and Nazareth Lodge became essentially a home for boys up to the age of eleven, though occasionally an older boy was permitted to stay on in order to attend a school in Belfast. This system continued until 1972. This change also addressed the concern that, in being cared for by the nuns, the older boys at Nazareth Lodge had had no male role models during their adolescence.

42 This development had a number of consequences. One was the change in group dynamics without the influence of the older boys. Witnesses such as HIA 159 said that when the older boys moved to Rubane in 1951 there was no more abuse from them, which was a great relief.[25] HIA 159 said that with the older boys in Rubane:

> "It was great when none of the older boys were there or the nuns, as we could throw water, soap and flannels about".[26]

The opportunity was used to break the large groups up and about 1951-52 the home was split into four groups. HIA 159 noted that each boy had a bed and a locker.

43 The development of smaller units was consistent with professional thinking at that time. The Home Office issued Guidance, which was circulated to voluntary organisations in Northern Ireland in 1952. This recommended the use of family group homes and it contained an appendix on ways in which large institutions might be broken down into smaller units in order to create family-sized groups and offer the children a more personalised type of care. The four units in Nazareth Lodge each had the capacity to hold about thirty boys, and each of these units was therefore still the size of a largish children's home, much bigger than the small groups recommended by the Home Office.

44 The early 1950s were a difficult time for agencies providing residential care. Belfast had suffered terribly from the bombing raids during the

24 RUB 10067.
25 SNB 593.
26 SNB 32191.

Second World War and nationally priority had to be given to housing. Food rationing only ended in 1953, the economy had not picked up, and the Sisters of Nazareth were still relying totally on financial support from the community to run the homes. It is not surprising therefore that standards of physical care were still very poor.

45 A detailed inspection report by Kathleen Forrest, an Inspector in the Ministry of Home Affairs, has survived from this period. She wrote that she visited Nazareth Lodge on 9 January 1954 and found that the babies were:

> "well-cared, well-clothed and fed" but "The whole premises - except the parts immediately above the laundry and boiler-house - were dreadfully cold. ...The babies' hands were blue with cold and felt icy to touch. ...The school-children are now the worst off and Rev. Mother agrees that they are not getting any sort of chance in life and cannot make proper development, especially those who have known nothing but this institutional care from babyhood. ...What is needed here is really fundamental re-organisation so that these little creatures can have some individual loving care instead of being dragooned. Rev. Mother recognises this and even went so far as to say that children playing in the gutters of the slums were better off, if they had a father and mother to care for them, however poorly".[27]

46 The needs of Nazareth Lodge were recognised in the distribution of grants in June 1954. £1000 had already been allocated out of the Ministry's budget to support voluntary homes, and a further £5000 was allocated to help with redecoration, upgrading the dining room, fencing, reconditioning the dormitories and providing toys. It was recognised that the headquarters of the Order in Hammersmith were not supportive of the "new-fangled" idea of breaking the dormitories up into smaller bedrooms, but this was clearly the Ministry's aim, in accordance with Home Office thinking.[28]

47 One of the reasons for the opening of Rubane at Kircubbin was to alleviate the pressure on Nazareth Lodge, as there was a considerable demand for places. Nazareth House faced similar problems and a number of children from both homes were sent as child migrants to Australia. The migration of children from Northern Ireland to Australia is dealt with in Chapter 6, but three of the migrants gave evidence in this Module.

27 SNB 16116.
28 SNB 16116.

48 It was also in 1953 that St Joseph's baby home was opened, superseding the Bethlehem wing at Nazareth Lodge.[29]

49 In the early years, nearly all of the children placed in the two homes were placed voluntarily. This meant that:

(a) the children's parents had requested, or at least agreed to, their placements;

(b) the placements had been arranged by their parish priest or someone else in a position of authority in the Roman Catholic Church, such as the Mother Superior of a nursery;

(c) by implication, the welfare authorities had not been involved in the placements, had not assessed the children's needs, were not accountable for the children's care, did not pay for the placements, and indeed were usually unaware of the children's existence.

50 The Sisters of Nazareth were at this stage reluctant to be beholden to the secular authorities, but their independence came at a price. In continuing the practice of voluntary placements they were choosing to forgo substantial payments by the welfare authorities, which affected their resources to improve physical standards of care and staffing. The welfare authorities for their part did not seek to involve themselves and were prepared to let the Catholic homes care at their own cost for children who otherwise might have needed to be taken into their care.

51 By 1956 the outdated nature of the large institutions was already noted. In *Children in Care*, a report by the Northern Ireland Child Welfare Council published by HMSO, it was concluded that the practice of voluntary placements was:

> "likely to lead in the future to serious difficulties unless allied with closer co-operation with welfare authorities"

and suggested that voluntary agencies should seek the help of the welfare authorities before admitting children. It was noted that:

> "some voluntary organisations are already committed to buildings that are difficult to alter".[30]

The report also addressed staff training needs, staffing ratios, inspection, discipline, domestic work expected of children and the danger of institutionalisation.

29 SNB 50495.
30 HIA 1752.

52 It was unfortunately another decade before the Sisters of Nazareth were offered financial and professional support from the welfare authorities, and while foster care was expanding and the welfare authorities were opening smaller homes (mostly family-sized) Nazareth House and Nazareth Lodge remained in their large and increasingly outdated buildings.

53 In establishing smaller groups within the two homes the Sisters of Nazareth were constrained not only by their limited resources but also by the number of sisters available, as they were reluctant for some time to appoint lay staff, for fear that the Order's influence might be weakened through the involvement of staff who had not committed their lives to the service.

54 The problems of the voluntary sector persisted and in 1966 *The Role of Voluntary Homes in the Child Care Service* was published for the Northern Ireland Child Welfare Council by HMSO. The report was based on visits to all voluntary homes and concluded that:

> "in the majority of homes it was evident that improved standards of accommodation, education and training were required".[31]

The homes were:

> "hampered to a greater or lesser degree by lack of money".[32]

The majority of homes had no trained field officers and decided on admissions without reference to the welfare authorities. Staffing levels were inadequate. Some voluntary organisations were concerned that they might lose their independence if they developed too close a relationship with the welfare authorities, but the report concluded that:

> "The best hopes lie in increased mutual understanding and sympathy and in an appreciation of what each has to offer the other". [33]

55 In 1968 Belfast Welfare Authority was the first authority to decide to allocate a social worker to every child in residential care. It should be noted that families became smaller, and the welfare authorities, and later the boards, increasingly undertook preventive work to support children at home, fostering services were developed and small children's homes were built. The result was that the children requiring residential care were fewer in number, were generally older, and were often more disturbed, having experienced failed foster placements, for example.

31 HIA 540.
32 HIA 559.
33 HIA 557.

56 The demands placed on residential childcare staff became more complex, and a higher degree of professionalism was required if homes were to continue to be used by the welfare authorities. Robert Moore expressed sympathy for the staff, saying that prior to the implementation of the Hughes Report's recommendations homes were essentially being run by amateurs, who were "understaffed, underpaid and undervalued".[34]

57 From the late 1960s onwards the two homes were affected by the Troubles. The families of many of the children lived in areas where there was social unrest, and the children would have been concerned about their safety. Unlike some of the other homes and training schools we have considered, neither Nazareth House nor Nazareth Lodge was directly involved in the Troubles (with the exception of one visit by soldiers looking for rifles, following a hoax call)[35] and they could be seen to have offered a safe haven for children from home areas where there was civil disorder and a serious risk of danger to the children and their families. The main problem identified by witnesses was that children and young people who had been protected from sectarian discrimination and violence when living in the homes had not been prepared to deal with it when they were discharged as teenagers, and this put them at risk.

58 In 1972 a two-storey extension known as the Bethlehem wing of Nazareth Lodge was converted into two small units, each with its own dining room and other daytime facilities on the ground floor and bedrooms on the first floor. Shortly afterwards, the main building was converted to create two more small units, so that the home now consisted of four family-sized groups.[36] It was probably this development which heralded the introduction of a number of improvements over the next two decades.

59 It was September 1972 before the Belfast Welfare Committee agreed that the remainder of privately placed children should be received into care and funded by the welfare authorities.[37] From then on, weekly capitation fees were paid and, as the Order's income increased, lay staff were recruited, and with the improved staffing levels the groups were also reduced in size, improving the opportunities for children to receive more individualised care.

60 Nazareth Lodge and Nazareth House both had large catchment areas and were seen as regional resources, but the majority of the children

34 SNB 6900.
35 SNB 10046.
36 SNB 50495,50497.
37 KIN 216.

came from Belfast. The Eastern Health and Social Services Board, which covered Belfast, however, added considerably to its own range of residential provision, which was more up to date and consisted largely of smaller homes. The demand for residential placements diminished as foster care was used increasingly, and the length of children's stay in children's homes was also being reduced as social workers found long-term foster placements for them. Having quoted the details of thirteen children who spent more than ten years of their childhood in Nazareth Lodge or Nazareth House and who were placed there voluntarily, HSCB stated that:

> "Within the Applicants there are no examples of children that were placed in Nazareth Lodge, Belfast, or Nazareth House, Belfast, by the welfare authorities at a young age, and who then remained in the Home for such a long period."[38]

61 According to Mother Gertrude's evidence to the Hughes Inquiry, it was in 1967 that girls were first admitted to Nazareth Lodge.[39] Originally, as noted above, Roman Catholic providers had divided their homes by gender and age as a way of coping with the high level of demand, but this basic framework had served to split families. Making the homes mixed countered this problem.

62 Both Nazareth House and Nazareth Lodge had their own schools at first. In 1974 the school on Ormeau Road at Nazareth House was closed and it amalgamated with the school at Nazareth Lodge, opening on 7 September 1974 under the name of St Michael's Primary School, which also provided services to children in the locality.

63 In 1975 the Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland) were introduced following the enactment of the Children and Young Persons (Northern Ireland) Act 1968, but their content was very similar to the 1952 Regulations.[40]

64 In the later years Nazareth House provided residential care for children in three units, which acted virtually as separate homes, although the heads of the groups were all technically accountable to the Mother Superior. However, as the numbers of children admitted dropped, various options were considered, and the sisters involved decided to propose to the Mother

38 SNB 100103.
39 SNB 50092.
40 HIA 288, 445.

General in Hammersmith that the home should be closed. In doing so they were following a pattern which was being replicated in homes run by the Sisters of Nazareth throughout the United Kingdom. Despite all the internal improvements, the buildings remained large and institutional and were now well out of date.

65 By October 1980 there were only two groups in operation with twenty children resident in all.[41] By September 1983 there were only four children remaining.[42] On 31 May 1984 Nazareth House, Belfast, was closed, having accommodated 2,909 children since its opening in 1876. It continued to care for older people until 2000, when it finally closed.[43]

66 From the early 1970s there were five family groups in Nazareth Lodge, with twelve children in each group, but by April 1985 the numbers had reduced to 38 children and there were only three groups. Demand for places continued to fall and the last child was admitted in 1998. In 1999 the home, which had accommodated 3,708 children since its opening in 1900, was closed. Despite a campaign to preserve some of the buildings, they were demolished and the site was redeveloped. Nazareth Care Village has replaced Nazareth Lodge.[44]

67 Between them the two homes had, therefore, in total accommodated over six thousand children and young people in a period covering approximately a hundred and twenty years.

Governance

68 As noted above, the Mothers Superior of the two homes were accountable to the Regional Superior who in turn was accountable to the Superior General in Hammersmith. Decisions about the policies and plans for the Order were taken by the Congregation, which met every six years and elected the Superior General.

69 The Order was independent and not, therefore, accountable to the local Bishop, but the homes had close working links with the Diocese of Down and Connor. The bishops visited frequently, providing pastoral oversight to the Sisters, and in 1938 Bishop Mageean turned to the Sisters to run a nursery for babies on its behalf. This work was undertaken by Nazareth

41 SNB 19859.
42 SNB 19862.
43 SNB 1958.
44 SNB 1959-1960.

Lodge until St Joseph's Baby Home was opened in 1953. The Bishop was supportive in the opening of Rubane, enabling Nazareth Lodge boys to transfer at secondary school age. The Diocese provided chaplains for the homes, and was also involved in the after-care of young people when they left the homes, as the Bishop was Patron of the Nazareth Lodge Welfare Committee.[45]

70 There is one reference to a House Committee being set up in 1952 for Nazareth House, chaired by Canon O'Neill to undertake the monthly statutory visits, but there is no information on its subsequent history.[46] There are references in the evidence to Nazareth Lodge having appointed a Management Committee in 1987 following the Hughes Inquiry, and it was treated as such, for example in its authority in establishing a subcommittee to inquire into complaints, but it had no managerial powers nor did it fulfil any statutory role.[47] It is considered in more detail in the section on inspection.

71 Prior to the 1980s, when the system changed, the Mother Superior of Nazareth Lodge was supported by two councillors, sisters who were drawn from the community who were not part of the residential child care staff, to provide her with confidential support. They met regularly, but their meetings were not minuted. The first councillor was older and more experienced; the second councillor was younger. This system was seen as augmenting Mother Regional's visits and meeting the statutory requirement for a monthly visit.[48]

Finance

72 The finance of residential childcare is dealt with more fully in Chapter 2, and the approach taken by the Congregation is considered in some detail in Chapter 5 concerning the Order's other two homes, Termonbacca and Bishop Street, Londonderry. This section is therefore brief and relates solely to Nazareth House and Nazareth Lodge, Belfast.

73 As an industrial school, Nazareth Lodge had a mixed role which was not well defined. On the one hand, training schools admitted young offenders and the most disturbed children, and on the other, children's homes were intended to take children who for the most part did not exhibit serious

45 SNB 17003-17312.
46 SNB 11290.
47 SNB 2291-2292.
48 SNB 9149.

behaviour problems. The remit of industrial schools lay in between; they were intended to take children on the verge of being in trouble, and prepare them for work.[49]

74 Some children at Nazareth Lodge were committed by courts, and the state funded their care. A Committee on Reformatories and Industrial Schools, set up by the Ministry of Home Affairs in 1922 reported in 1923 that funding for the schools was inadequate, and the Committee recommended a capitation grant of 2/6d per head per week from the Government and an equal amount from the relevant welfare authority.[50] By 1937 the Government payment had risen to 7/6d a week with an equal amount paid by the local authorities.

75 The boys committed by courts were aged 6 to 10; on reaching 10 they were transferred to St Patrick's. The numbers of committed boys were very low, however. In 1939 and again in 1944 there were only eleven committed boys, as against respectively 179 and 174 boys placed voluntarily by their families.[51]

76 When Nazareth Lodge became a children's home in 1951 the welfare authorities presumably replaced the state in taking responsibility for such placements, but the numbers placed under Fit Person Orders were also very low. The income from such placements was too small to have a significant impact on the home's budget. Some children were placed in the homes by welfare authorities, and there is a record of Belfast Welfare Committee paying £3 per week for a child's maintenance in 1956.[52] The numbers funded in this way at that time were, however, small, and the Sisters of Nazareth took no steps to increase their income by requesting that other children were funded by their welfare authorities.

77 The Sisters of Nazareth raised all the funds required for the provision of the services that they offered to boys admitted voluntarily. According to HIA 159:

> "The nuns used to go out every Wednesday and Saturday with their black bags and go door to door collecting. …They were known as the penny nuns",

49 The categories of children included neglected children, offenders under the age of 12, children under 14 who were beyond parental control, and children who persistently failed to attend school or refused to submit to reasonable school discipline. (SNB 13639).
50 SPT 17108.
51 SNB 13708, SNB 13750.
52 SNB 15535.

because they never refused to accept even a penny.[53] Some of the sisters were designated as 'questers' to undertake the collection of funds, and it should be noted that many of the people who donated were from the poorer sections of the community. SR 52 said that the rate paid to Nazareth Lodge by Health and Social Services Boards was low for voluntary homes and they could not have managed without these voluntary contributions.[54] The rates were, however, based on data provided by the homes which, pre-1973, took account of the income which the homes could raise voluntarily, though the later per capita fees ignored this. Furthermore, as the HSCB has pointed out, there were additional grants to cover birthday and Christmas presents, and holidays. The level of donations can be seen in the records for 1973-1984.[55] There was also a steady flow of legacies; some of these were sizeable, but they were not a reliable source of income.[56]

78 Businesses also contributed in kind, donating clothing or food. There are references, for example to Marks and Spencer providing food. Others, such as Mackies, provided parties for the children at Christmas, which were much appreciated. The problem was not as acute as in Londonderry because the economy in Belfast was stronger, but raising sufficient funding remained a major problem.

79 HIA 159 also noted:

> "There were also open days when hundreds of people were allowed to come up and look around to see where all the money the nuns collected door to door was going".

There were badges with a boy's face on it for 6d or a shilling, sold in the early 1960s.[57]

80 Some income was obtained from parents, but it is likely that this was more of a token gesture than a serious source of finance. HIA 204 said his mother paid 10/- per week for his upkeep. HIA 36 said his mother paid £5 a month throughout his stay at Nazareth Lodge.[58] HIA 43 said that although her father was not well off he was intimidated by the nuns into giving them money, handing over ten shilling notes on numerous occasions, and that they took advantage of him as he was a countryman.[59]

53 SNB 32183.
54 SNB 1593.
55 SNB 16465.
56 SNB 16554-16616, 100066.
57 SNB 32185.
58 SNB 425.
59 SNB 711.

81 The witnesses' evidence contains a number of examples where small amounts of money were taken from children, after visits to families, for example. The Order has stated that this was done for safe-keeping, but none of the witnesses mentioned receiving the money later. Working children were also charged for their keep. Similarly toys, clothes and sweets were taken from children, and it was believed by witnesses that these were sold in other parts of the country to raise funds though this was denied by the Sisters.[60]

82 As noted earlier, the Order wished to remain self-sufficient, in order to avoid becoming beholden to the state. The consequence of the Sisters' approach was that, while the nuns themselves received no salary and only required their keep, the Order had insufficient resources to appoint paid staff. As HIA 87 put it:

> "Everybody had a job to do. ...they didn't have the staff to run the place."[61]

83 There was a steady increase in the number of placements financed by the welfare authorities. By March 1965 there were 88 voluntary placements and 31 funded by the welfare authorities in Nazareth House, and in Nazareth Lodge 81 placements were voluntary and 28 were paid for by the authorities.[62] From 1973 the Health and Social Services Boards paid a per capita rate in both Nazareth House and Nazareth Lodge, irrespective of whether the children had been placed by the Boards or privately by their parents. The amount took account of the fund-raising undertaken by the voluntary bodies however, and the Sisters' success in obtaining donations and legacies therefore reduced the income they received from the state.[63] The Boards negotiated rates with each voluntary home and the HSCB accepted that at first they did not meet the actual costs of placements. They explained that in some cases this was due to lack of full information about the actual costs, but that it was more generally due to the Boards increasing the rates they were prepared to pay incrementally. The HSCB acknowledged that the voluntary sector argued in 1985 that the Boards were expecting them to provide a professional service provided by suitably trained staff without paying the economic rate for such care[64] but argued that the Boards did support the voluntary sector to professionalise its workforce. The weekly payments to the voluntary sector

60 Day 96, p.141.
61 Day 83, p.40.
62 SNB 16623.
63 SNB 100106.
64 SNB 100107.

ranged from £42 to £198 in 1985, while the average cost of residential care per week in homes run by the four Boards ranged from £185 to over £250.[65] By 1991 Nazareth Lodge had accumulated a deficit of £45,000 this was cleared by a one-off grant from the Eastern Board, which was helpful, though it was unsatisfactory as a method of resolving an ongoing revenue problem.[66]

84 The matter was unresolved when Nazareth House closed, but the improvements made in the 1980s were substantial. In consequence there was sufficient funding both to improve physical standards of care and to appoint paid lay staff. Indeed, as the number of sisters diminished, the balance between lay and religious staff changed until the sisters' role was primarily to act as the managerial staff in charge of the units. By the time Nazareth Lodge closed, some of the team leaders were lay staff. This change was paralleled by an increase in staff training for both nuns and lay staff, and the introduction of a more professional approach to residential social work.

85 Following the implementation of the Children and Young Persons (Northern Ireland) Act 1950 state funding was available to voluntary providers under Section 118 to improve premises or equipment. This measure proved problematic as welfare authorities were required to contribute towards the funding, but the decisions on approval were taken by the Ministry of Home Affairs. The welfare authorities therefore found it difficult to budget as they had no idea what the level of demand might be and they resented having to pay towards services which they did not use. Tyrone County Welfare Committee, for example, protested about contributing to grants to Nazareth Lodge. [67]

86 The grant awarded in 1954 by the Ministry of Home Affairs has already been mentioned.[68] The Ministry also paid grants to assist in providing qualifying training for staff. Typically this covered fees, expenses and replacement staff, though in the period before the Order started to employ lay staff the need for additional staff salaries might not have applied. Nazareth Lodge is recorded as having received £1000 in 1954 for this purpose, but the records do not detail how the money was used.[69]

65 SNB 100107.
66 SNB 100116.
67 SNB 16461.
68 SNB 16113-5.
69 SNB 15822.

87 Homes run by the Order could apply to the mother house in Hammersmith for loans, but the expectation was that such loans would be repaid, for example when legacies were received. In 1980, for instance, there is a record that £10,000 was repaid and, when in 1983 Nazareth Lodge was in difficulties prior to a substantial increase in the per capita allowance, a further £30,000 was borrowed from Hammersmith.[70]

Inspection

The Order's Systems

88 The Sisters of Nazareth had their own internal inspection system. The Superior General, who was based in Hammersmith, visited all homes once every three years and conducted a full inspection, which included the spiritual life of the community as well as the childcare. Mother Regional, who was responsible for all the services in both the Republic and Northern Ireland, was based in Dublin and typically visited three or four times a year, though she told the Hughes Inquiry that she had visited Nazareth Lodge 13 times in 1984. In evidence to the Hughes Inquiry Mother Gertrude, the then Mother Regional, said that the statutory requirement to undertake the monthly visits required under the Regulations rested with her.[71] If she typically visited only three or four times a year, this would have fallen well short of the statutory requirement of monthly visits.

89 In a report dated 14 April 1996 SR 189 said that in the 1950s Nazareth House had a committee consisting of the School Manager, the Local Superior, two teachers from the school and the sister in charge of the children. This committee met monthly and received reports from their appointee who visited the children; according to SR 189 any recommendations they made were implemented. It was a system established by the Congregation and was not intended to fulfil statutory visiting requirements.[72]

90 In October 1984, as a result of the Hughes Inquiry, a monitoring team was set up for Nazareth Lodge. The Committee was referred to as the Management Committee but its role was strictly advisory. Pat Kinder, who had been a senior administrator in the Eastern Health and Social Services Board, was invited by SR 36 to set up an Advisory Committee for Nazareth Lodge. He contacted a number of persons who had professional skills in

70 SNB 19896,19897.
71 SNB 50044.
72 SNB 16906.

sociology, psychology, medicine, teaching and the law.[73] All agreed to help; SR 36 approved the list and Pat Kinder agreed to act as secretary.

91 The members of the Committee were allocated to one of the three groups within the home and they visited, meeting both staff and children. The Committee met monthly with the three sisters in charge of the groups and discussed any issues which they wished to raise. The Committee's purpose was to give the children access to someone other than their carers, and they inspected the complaints book.[74] SR 18 referred to a committee of volunteers who carried out monthly inspections in the 1980s and 1990s, which presumably was this Committee.[75] This Committee was asked to produce a written report every six months, to be presented to the Sister in Charge and Mother Regional.[76]

92 Neither the advisory systems to support the homes' Mothers Superior described above, nor the (approximately) quarterly visits of the Mother Regional, appear to have met the statutory requirement laid down in paragraph 4 (2) of the Children and Young Persons (Voluntary Authorities Homes) Regulations (Northern Ireland), issued in 1952 and reiterated in 1975, that both the homes should have been:

> "visited at least once in every month by a person who shall satisfy himself whether the home is conducted in the interests of the well-being of the children and shall report to the administering authority upon his visit and shall enter in the record book ... his name and the date of his visit". [77]

Mother Regional acknowledged that it was her role to meet this requirement, but her visits appear to have been too infrequent and there is no indication that reports were prepared on the visits. The other support systems were explicitly advisory. **We consider the failure to meet the statutory requirement for both Nazareth House and Nazareth Lodge to be visited monthly to have been a systemic failure.**

State Systems

93 As an industrial school Nazareth Lodge was inspected annually by the inspectors from the Ministry of Home Affairs. The Ministry was authorised

73 SNB 2291.
74 SNB 50043, 50044, 50049.
75 SNB 1860.
76 SNB 50048-50049.
77 HIA 288.

to inspect under Section 46 of the Children Act 1908, but the Ministry had no direct control over the training schools and industrial schools which it inspected. Its limited remit was to report on the health of the children, the conditions in which the children were kept and the schools' record-keeping. Reports dating from 1927 to 1944 are extant, and they are broadly positive about the state of the premises, the health of the boys and the training and education being offered. Visits made by Ministry of Home Affairs Inspectors to Nazareth Lodge from 1950 onwards are listed in Annex C of the evidence prepared by Dr Hilary Harrison, indicating consistent annual visits.[78]

94 Following the passing of the Children and Young Persons (Northern Ireland) Act in 1950, Regulations were introduced for voluntary children's homes, and these would have been applied to Nazareth Lodge which had been re-registered as a children's home. (These Regulations appear to have been based on Regulations which had been applied in England and Wales following the Children Act 1933, which was not replicated in Northern Ireland.) In 1975 the Regulations were updated, following the 1968 Act, but they remained largely the same.

95 The Regulations were applied by the Ministry of Home Affairs, and there are records to indicate that Kathleen Forrest visited Nazareth Lodge. Her visit reports indicate real concern for the children, awareness of the practical issues, and a desire to take action to remedy unsatisfactory conditions.[79] Her visits were not considered to be formal inspections, such that neither Nazareth House nor Nazareth Lodge was deemed to have been inspected until 1983.[80]

96 The Social Work Advisory Group was established in 1973, the DHSSPS (now DoH) has claimed that adopted a new approach, by which it offered advice and support, and ceased to undertake annual inspections. In the light of Kincora and the Hughes Inquiry the advisory approach was dropped and a more rigorous inspectorial approach was resumed. This development and the philosophy behind the changes of policy are examined more fully in Chapter 2.

97 The effect of these changes was that there was a hiatus of several years in which there were very few formal inspections. The Social Work Advisory Group carried out an inspection of Nazareth Lodge in October 1983 and

78 SNB 9576.
79 SNB 16116.
80 Day 111, pp.68-70.

provided evidence to the Hughes Inquiry.[81] From 1985 the Social Services Inspectorate undertook annual inspections, the last being in November 1995.[82] Our criticisms of the lack of inspection by SWAG and the content of the inspections referred to above are dealt with in the respective sections of this chapter on the two homes.

98 The SWAG and SSI also had a co-ordinating role. Following the Sheridan Report and the Hughes Inquiry there were annual "Review of Registration Meetings" at which SWAG, the Department's Policy Branch, voluntary providers and Boards were all represented, and these meetings were used to discuss the planning of residential childcare provision.[83] These developments did not affect Nazareth House, which had closed by this time.

Finding

99 **We consider the failure to meet the statutory requirement for both Nazareth House and Nazareth Lodge to be visited monthly to have been a systemic failure.**

81 SNB 50232-50266.
82 SNB 13813-13864.
83 Day 118, pp.72-75.

Contents

Chapter 8:

Module 4 – Sisters of Nazareth, Belfast: Nazareth House

Site and Premises

1 Nazareth House was sited on a wedge-shaped piece of land at the junction of Ravenhill Road and Ormeau Road on the south side of Belfast. The site also housed a home for older people.

2 At the front of the building there were rooms for visitors, where the chaplain had his breakfast after Mass. The residence for elderly men was on the ground floor on the Ravenhill side. There was a long corridor on which the classrooms were situated and beyond them, the girls' dining room. There was also a staircase leading to the first floor. The elderly ladies lived on the first floor, and there was the chapel and a large hall, used for entertainments.[1] The bedrooms for the children were on the upper floors, and during the period when many of the allegations were made, there was a partition and an open doorway dividing the dormitories, with 20 beds on one side and 19 on the other.

3 There were three gardens. The nursery garden for the little children had railings round it. The girls' garden had swings and climbing frames which were in constant use, and they used the garden also for skipping and netball. The nuns' garden, which was full of flowers, was only open to children on special occasions.[2] HIA 234 noted:

> "There were big walls all around Nazareth House and there were bits of broken glass embedded in the tops of the walls, as well as barbed wire".[3]

Whether this statement is factually accurate or not, it conveys the sense that the home was an enclosed community which met all the children's needs on site.

The Groups

4 In the 1940s there were three groups, named Our Lady's, St Joseph's and Sacred Heart, which was for the younger children. The names appear to have changed at some point, as St Joseph's was replaced by St Anne's. Our Lady's wore blue for Sunday Mass; Sacred Heart wore red; St Anne's green.[4] The girls wore tweed skirts and matching jumpers in the colour of their group on Sundays and, as weekday uniform for their primary school,

1 SNB 80077.
2 SNB 818-819.
3 SNB 334.
4 SNB 043.

gingham dresses.[5] In the early 1950s the seniors and juniors were divided into three groups of about thirty children in each group. During the period covered by the majority of the allegations of abuse, they were Our Lady's, under SR 31, St Anne's, under SR 116 and Sacred Heart, under SR 134. The nun responsible for the group slept in a small cell in the corner of the dormitory.[6] In the 1960s cubicles were installed, providing some privacy in the dormitories.[7]

5 About 1972 the big dormitories were replaced with smaller bedrooms for three girls. The girls were also given thicker mattresses and minty toothpaste and scented soap instead of carbolic,[8] a wardrobe, cupboard and chest of drawers.[9] Writing about Nazareth House in 1973, SR 18 said:

> "At that time there were three independent family groups in the home, each supervised by a sister; each group consisted of eight to ten children, made up mainly of two to three sibling groups. The units had just been refurbished. The layout of each was very homely, easy to manage and tastefully decorated. It consisted of four bedrooms, each with two/three beds, a lounge, dining room with adjoining kitchenette, a study room, two bathrooms/toilets, a laundry room and a bedroom for each sister."[10]

About 1975 the numbers reduced to under twenty and so two groups were amalgamated. Another sister arrived, so that there were two per group. Boys were admitted about this time.[11]

6 The cooking of the main meals still took place in the central kitchen, with the food taken by trolley to the groups' dining rooms. Food was supplied at no cost by Marks & Spencer at this time, including marzipan cakes, big bags of crisps and meat.[12]

7 When they were aged 16, the girls moved from the children's section to the girls' dormitory, where they had curtains round beds and could stay up till 9 pm. HIA 28 commented that it was great to have that privacy.[13]

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5 SNB 819.
6 SNB 181.
7 SNB 330.
8 SNB 677.
9 SNB 820.
10 SNB 1580.
11 SNB 1581.
12 SNB 820.
13 SNB 049.

Daily Life

8 In the following sections a number of aspects of daily life in Nazareth House will be considered. It will be seen that some of these indicated poor or unacceptable childcare practice, while others reflected standards which would have been acceptable at the time. It should be noted that approximately three quarters of the allegations were made by witnesses who were in the home in the 1950s and 1960s. The number of allegations relating to the 1930s and 1940s is understandably lower, but there was a significant reduction from 1970 onwards. As noted above, the quotation of evidence does not necessarily imply that it is accepted as accurate.

Admission

9 It is recognised in residential childcare that the admission process is critical, not only in helping a child settle in to a children's home but also in establishing their understanding of what is happening to them, why they can no longer be at home and what will happen to them next.

10 HIA 387 found admission to Nazareth House in 1953 an intimidating process. She said that a nun dragged her along the hall by the hair, her doll was taken from her, and she was given the number 49.[14] HIA 370 said the clothes she wore on admission were handed to other girls to wear when they went out to visit their families.[15]

11 HIA 95 said that the admission process for her and her two sisters in the early 1950s took all day, as they were stripped, bathed, put in different clothes and deloused by older girls.[16] HIA 375 found the admission process daunting. She and her sisters were taken to Nazareth House by their parents but the children were never told why their mother and father were leaving without them.[17] Throughout her time in the home she was tearful and clung to her sisters.[18]

12 In 1960 HIA 43 was placed in the nursery section while her older sister went into the girls' group. It was only in the segregated playground that they saw each other, and HIA 43 said that even then the nuns pulled them apart if they tried to touch each other. She felt that this was cruel

14 SNB385.
15 SNB 380.
16 SNB 661.
17 SNB 730.
18 SNB 731-733.

and inhumane, as they should have been allowed to comfort each other.[19] She stated:

> "My first memory of Nazareth House was the sheer loneliness which hit you as soon as you walked in the door. We were just left in beds and cots crying. The nuns never showed any warmth or affection; they never touched you. To this day I cannot stand being touched as a result of this".[20]

13 The evidence above suggests a lack of explanation, a failure to provide affection to compensate for the loss of family, and a process which was designed to accustom the children to institutional living. In our opinion the practices described failed to meet acceptable standards of childcare at that time. However, the dates of the evidence indicate that these witnesses were admitted when staffing was inadequate, and it would have been difficult for the sisters to give children the time and individual care and attention they needed on admission, though this would not excuse measures such as the confiscation of dolls.

Routines

14 HIA 161 said that the girls were woken every morning by a nun ringing a bell,[21] though HIA 32 said that a whistle was used in the 1930s, when, as seven or eight year olds, their first task was to go in their nightdresses and bare feet to polish the chapel.[22] HIA 327 described SR 31 coming into the dormitory and clapping her hands to get everybody up.[23] HIA 171 said that they got up each morning at seven, knelt down by their beds to say their prayers, made their beds and then went to Mass. When they came back from Mass they had breakfast (as with other meals) in silence.[24] According to HIA 20, this practice changed about 1960.[25]

15 SR 18 said that by the 1970s older children got up at 7.30 am to give them time to walk to school, while younger children, who went to a school in the grounds, got up at 8am. Transport was arranged for children attending special schools.[26]

19 SNB 710-711.
20 SNB 711.
21 SNB 145.
22 SNB 234.
23 SNB 792.
24 SNB 780.
25 SNB 181.
26 SNB 1580.

16 In the 1970s, children were back from school between 3.30 pm and 4 pm, and after a snack they changed out of their uniforms, did homework or watched television. According to HIA 161 there was Benediction every afternoon.[27] HIA 117 said:

> "There was a garden with swings and climbing frames in it. We got to be outside for one hour each day. That was when you got to speak to other children and a nun would have walked around the garden with her prayer book watching you. I like to read a lot, but there was nothing to read. The TV was very limited. You had to watch mostly what the nuns wanted to watch."[28]

17 According to HIA 20 the evening meal was at 5.30pm. They had semolina pudding, or bacon and bread, or cheese and bread, but she said they always went to bed hungry.[29] At 6pm there was the Angelus. The meal was followed by television, games, or activities such as swimming, ice skating, the cinema, local clubs, guides, Irish dancing and ballet.[30]

18 During the evening the lay staff supervised the children while the nuns spent time in their community, sharing a meal and in worship. During the earlier years, while the nuns were praying, older girls were left in charge. HIA 43 observed that as the older girls had been bullied themselves, they in turn bullied the younger ones once they had power. She said that, by way of example, even though the girls only had short dresses and were crying to come indoors, the older ones locked them out in the yard.[31]

19 At night the girls had to sleep with their hands crossed over their chests. HIA 14 said that SR 116 explained that this was so that they would go to heaven if they died in their sleep. She told them that if their arms were not crossed they would burn in hell.[32] HIA 439 surmised that it was so that they would not interfere with themselves, and said that if they were found with arms uncrossed, they were hit hard.[33]

20 On Fridays the girls had confession, for which they "would often make up stories about any sins we had in order to have something to say", and there were the Stations of the Cross.[34]

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27 SNB 145.
28 SNB 780.
29 SNB 181.
30 SNB 1580-1581, 1858-1859.
31 SNB 711.
32 SNB 116.
33 SNB 204.
34 SNB 145.

21 Also on Friday nights there was inspection of underwear and the provision of clean clothes. HIA 129 said that in the 1940s, the clean clothes were laid out in semi-circular rows and when they had changed into them the girls had to take the dirty underwear to the nun for inspection. She remembered:

> "...trying to figure out why I had to show the nun my underwear when my mother had never made me do this."[35]

It was reported that the girls wore slips during the underwear inspections.[36] though HIA 387 said the girls stood naked in the big hall and:

> "If my underwear was soiled, I would be punished and called a rank, smelly, dirty girl."[37]

Having dirty underwear merited "a couple of whacks on the palm of your hand" with a cane, and according to HIA 62 SR 122 used to give a girl with dirty underwear "a crack round the head". One consequence was that on a Friday night the older girls bullied the younger ones into swapping underwear to avoid trouble.[38]

22 The rationale for this routine is unclear. HIA 223 was of the opinion that the purpose of the inspection was to show who was in charge.[39] The Order said that they were aware of these allegations but denied that they were common practice.[40] Systems for changing clothes such as that described above would have been good institutional practice in dealing with a large number of girls. We find the witnesses' accounts about the use of the occasion to conduct humiliating inspections coupled at times with punishment convincing, and this practice was unacceptable.

23 Saturdays were spent by the girls fine-combing each others' hair, polishing shoes, darning socks and, once a month, changing their bedding.[41]

24 On Sundays they went for walks and played for half an hour in Ormeau Park, but they were told not to speak to anyone from outside.[42] If it was very wet they played in the hall.[43]

35 SNB 018.
36 Day 99, p.177.
37 SNB 387.
38 SNB 672.
39 Day 95, p.107.
40 SNB 2093.
41 SNB 182.
42 SNB 182.
43 SNB 183.

Chores

25 The 1952 Home Office Guidance said that:

> "Boys and girls should be expected to take a moderate share in the daily running of the home" and should "progress from light routine tasks, such as dusting, bed-making and washing up, to skilled work such as cooking, bottling [and] ironing…" They could also be "given some responsibility for planning meals, purchasing household goods and checking the laundry".[44]

Sr Brenda said:

> "Whilst children would have been asked to carry out some chores such as polishing the floors and assisting with tidying the dining area and making beds, these chores were appropriate to their age and were not excessive."[45]

26 We received a considerable amount of evidence on this subject. HIA 166 said that all the children in the home had to do the cleaning:

> "From the age of seven or as soon as you could kneel down, you'd be scrubbing."[46]

HIA 361 also emphasised the involvement of all the children, whatever their age:

> "We were all trained in cleaning. We started our chores at the age of five and these would have been lighter chores. At the age of seven we would have been given something harder to do, and again, a few years later, the chores would have got worse".[47]

27 Some witnesses focused on the excessive nature of the chores. HIA 43, for example, said that they were "treated like slaves", "forced to scrub", "constantly down on our hands and knees scrubbing with deck brushes and orange wax", till her arms were aching and her back was in agony.[48] HIA 223 wrote:

> "We were glorified slaves for the nuns. We were exhausted. We got nothing for all the work we did".[49]

HIA 387 felt that the nuns were "trying to break them down".

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44 HIA 475.
45 SNB 2165.
46 SNB 290.
47 SNB 371.
48 SNB 714.
49 SNB 315.

28 Others pointed out the inappropriateness of some of the work for children. HIA 197 said that she had to work in the laundry. She had to rinse out soiled sheets, including bedding from the old people's home, till her fingers were raw, and to reach the sink she had to stand on a stool. She then put the sheets in an industrial washing machine, pressed them and folded them up. Eight or ten girls assisted the lay laundry workers in this way.[50] [51] HIA 37 said that at the age of thirteen she was made responsible for the upstairs bathroom, which had thirty sinks, four toilets and four baths. She also had to dispose of the soiled sanitary towels in the furnace every Tuesday which, she said, the nuns termed a privilege.[52] HIA 29 said that her chores included cleaning, laundry work, shovelling coal into the furnace, scrubbing the halls, dormitories and church, polishing the pews, and cleaning the nun's cell in the corner of the dormitory.[53]

29 Girls were at times asked to help out in the old people's home. HIA 61 started when aged seven, laying the tables. She said that none of the girls enjoyed working with the old men, as they tried to touch the girls.[54] At the age of nine or ten she was told to wash and lay out the body of an elderly female resident whom she had known, and she was punished by SR 116 for not putting cotton wool in her orifices. She was then required to pray for her soul in the "dead house". This incident affected her badly.[55] Sr Brenda said:

> "While [HIA 61] may have helped in the old people's home, she would have been merely assisting a lay staff member or Sister in carrying out their duties."[56]

The question remained whether a young girl should have been undertaking such duties at all.

30 HIA 117 said that between the ages of nine and fourteen she helped out in the old people's home, bathing old ladies, changing nappies, sitting up with the dying, and washing dead bodies.

> "[SR 31] said it was to get the devil out of me and to keep me away from the other children."[57]

50 SNB 694.
51 Day 95, p.22.
52 SNB 055-056.
53 SNB 011,012.
54 SNB 768-769.
55 SNB 772.
56 SNB 2149.
57 SNB 875.

The Order did not accept that HIA 117 did more than assist in the lighter duties.[58] However, HIA 335 said that in the 1940s she also helped in the morgue from the age of ten, dressing the bodies and putting pennies in their eyes, which petrified her.[59]

31 There were additional chores at weekends and during the school holidays, ranging from polishing wooden floors in the recreation hall[60] to going up high ladders to wash the walls.[61] A summertime job was the painting of the bed-frames, in which some of the girls helped the handyman.[62] The Order said that the girls would not have been expected to paint their bed-frames every summer.[63]

32 HIA 166 said that a nun or an older girl supervised the work and substandard work was punished with a clip across the ear, a punch or a kick.[64] HIA 37 said "I never once saw the nuns do any physical work, always the children."[65]

33 By the mid-1970s the emphasis on chores appears to have diminished; floors, for example, were mopped rather than scrubbed.[66]

34 Even if one allows for a degree of exaggeration through the passage of time colouring the memory, it is clear that the girls at Nazareth House were expected to do an excessive amount of chores, starting at an early age. In most children's homes domestic staff would have been appointed to clean communal areas, and the residential care staff would have participated, for example in cooking meals or doing laundry when the ancillary staff were on holiday or at weekends.

35 One argument for involving children in chores is to accustom them to household work with a view to having the necessary skills for independent living. However, the tasks described by the witnesses refer to a laundry functioning on a commercial scale and the cleaning and polishing of large rooms such as the dormitories, hall and chapel; this was no help in learning how to cope on a domestic scale. It seems likely that the involvement of the girls in chores on this scale was of long standing, dating

58 SNB 2172.
59 SNB 025.
60 SNB 290, 684.
61 SNB 004.
62 SNB 767.
63 SNB 2148.
64 SNB 290.
65 SNB 056.
66 Day 100, pp.85, 87, 88, 129.

back to the early days of the home, at a time when girls would have been expected to play a major part in house-work in families. Using the girls as the workforce (rather than employing domestic staff, as in most children's homes) would have kept costs down and kept the girls occupied, but neither of these arguments is acceptable as a rationale in the period we are considering. **Many of the tasks which the girls were required to perform were of little use to them as preparation for managing their own households, and in our view the excessive chores expected of the girls constituted systemic abuse.**

Bathing

36 Complaints about the systems used for bathing ranged from the 1940s, when there were only girls in Nazareth House, to the late 1960s, when boys were also admitted. HIA 439 said that in the 1940s bath day was on a Thursday and there were three baths of different sizes. Hair was washed in the first bath; then the girls were dipped in Jeyes fluid, resulting in red eyes the following day. They cleaned their teeth with washing soda or soap at first, but a new Mother Superior introduced toothbrushes.[67] It was also during the 1940s that HIA 361 said that on one occasion SR 145 sent her back to wash again eight times as she had a swarthy neck. She lost her temper and pulled SR 145's "habit" off (presumably the nun's wimple, as her ginger hair was visible), for which HIA 361 was punished.[68]

37 The 1952 Home Office Guidance emphasised the need for children to learn about personal hygiene and to care for themselves. They were each to have all their own equipment such as towels, flannels, toothbrushes and toothpaste, and fresh water was recommended for each child when bathing.[69]

38 First thing in the morning in the 1950s, according to HIA 387, the girls were stripped naked and walked down cold halls to the bathroom, which she found embarrassing.[70] In the 1950s and 1960s, bath days were Tuesdays and Fridays[71] and bathing was in three stages. First, girls washed their feet and knees beside the bath; then they sat in the bath with Jeyes fluid; finally they stood in a corner to dry themselves.[72]

67 SNB 205.
68 SNB 373.
69 HIA 474-475.
70 SNB 386 and SNB 387.
71 SNB 183.
72 Day 95, p.108, SNB 663.

39 Contrasting with HIA 387's and HIA 14's account below, there was an emphasis on modesty. HIA 166 said:

> "We wore a sleeveless shaped shift dress garment while we had a bath so we couldn't see what our bodies looked like. We used a flannel under the dress to wash ourselves".[73]

When the girls got out of the bath a sheet was held up to conceal them while drying.[74]

40 The use of Jeyes fluid was a recurrent theme. HIA 14 said:

> "We were bathed in Jeyes fluid and scrubbed all over with carbolic soap, including our genitals. The older girls would have scrubbed us and the nuns would just have supervised. It was awful and it made my skin and my vagina really sore. I suffered from eczema and I think it was as a result of the carbolic soap".[75]

41 According to HIA 327, older girls supervised the bathing and could be rough.[76] HIA 84 said that the older girls were in charge at bath times and that they used a fine tooth comb for nits, hurting their scalps. She felt that some of the older girls had been treated badly over the years and they were repeating their experiences in maltreating the younger girls.[77]

42 HIA 387 said that there were special arrangements for hair-washing. The girls had to stand in their underwear in the yard for their hair to be washed in big tin baths, regardless of the weather. The nuns cut their hair off if there were nits, and poured Jeyes fluid onto their skin.[78] HIA 63 said:

> "There were three tin baths for washing our hair out in the yard - one for each group. We had to queue up and take our turn. The water was warm but it was never changed so you were lucky if you got washed first you got the clean water but if you got washed last the water was filthy".[79]

43 HIA 368 was aged eight on admission in 1969 and was placed at Nazareth House as he refused to be parted from his sister. At bath time he shared a bath with the older girls.[80]

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73 SNB 294.
74 SNB 294.
75 SNB 117.
76 SNB 794.
77 SNB 724.
78 SNB 387.
79 SNB 684.
80 SNB 656.

44 In view of the cost of heating bath water, sharing would have been common practice in many households in the earlier decades, despite the Home Office Guidance. However, **the infrequency of changing the water, the use of carbolic soap to clean teeth, the use of Jeyes fluid in the bath, the rough treatment of younger girls by older ones when bathing and washing hair, and the queuing were outdated institutional practices which should have been superseded or never adopted in the first place, and they constituted systemic abuse.**

Bedwetting

45 According to HIA 62 bedding was adequate though the mattresses were thin, and there was a lukewarm central heating system.[81] In the earlier years the mattresses had brown mackintosh covers, presumably as a universal response to possible bedwetting.[82]

46 Many witnesses reported that the nuns took a punitive approach to bedwetters. HIA 30 said that in the 1940s, children had their wet sheets draped over their heads.

> "They would be lined up inhaling their own urine in the freezing cold. Everybody lived in fear of being associated with the 'wetbeds'".[83]

HIA 62 said she witnessed SR 134 making an eight-year-old who had wet her bed kneel by her bed with the wet sheet over her body. SR 134 was reported to have said:

> "Yes, you can smell that for the rest of the night."[84]

The Order did not accept that this happened.[85]

47 HIA 197 said that SR 134 "degraded" bedwetters in front of everyone else, on one occasion rubbing HIA 197's nose in the wet sheets.[86] HIA 387 made the same allegation.[87] HIA 370 both wet and soiled her bed, and she said she was punished by having to sleep in a wet bed. One night, perhaps because she had soiled herself, she was hosed down by a nun in the presence of a man. She said she went to bed, soaking wet,

81 SNB 672.
82 Day 99, pp.74 and 75.
83 SNB 756.
84 SNB 673.
85 SNB 2112.
86 SNB 692.
87 SNB 387.

unable to breathe because of asthma.[88] HIA 316 said that bedwetters had to queue up outside the nun's cell to be caned.[89]

48 These practices were said to have continued when boys were admitted to Nazareth House. HIA 175 said that most children had to line up on the right of the corridor to go down in a single file to breakfast. The children who had wet their beds, including her little brother, HIA 368, had to stand on the left hand side with their sheets over their heads.[90] The Order stated that they could not accept that this could have happened.[91] HIA 175 said her brother smelt of Jeyes fluid. She attempted to steal sheets from the laundry so that she could change his bed and conceal his sheets. He corroborated her account.[92]

49 It seems that the bell and pad system was introduced about 1950. HIA 166 wet her bed regularly; her bed was moved to be near the nun's cell and a bell and pad system was tried for one or two weeks, but her bedwetting continued. About 1951-52 she attended the Royal Victoria Hospital for tests.[93] A number of girls used the bell and pad system, including HIA 197 when she was 13 or 14. One of the problems about employing the bell and pad was that it awoke everyone in the dormitory. HIA 124 said that when the alarm went off SR 31 grabbed her out of bed and beat her.[94] HIA 117 said that when bedwetters were given alarms, hers always went off first, and SR 31 used to come out of her cell and give her "a terrible hiding". According to HIA 30, if the buzzer system went off SR 31 "would go mad" and make the girl kneel by her bed in her wet nightie the rest of the night. Sometimes SR 31 shouted to an older girl to deal with it.[95] Girls who wet the bed were also given some purple medicine, but this proved ineffective.[96] HIA 197 summarised:

> "I believe we were wetting the bed because we were a bundle of nerves" and "It was an awful way to treat a child".[97]

50 SR 153 was at Nazareth House from 1970 to 1973, by which time, the children lived in smaller groups. She put all the bedwetters in one

88 SNB 381.
89 SNB 828-829.
90 SNB 162.
91 SNB 2053.
92 SNB 162, 656.
93 SNB 289 and SNB 290.
94 SNB 837.
95 SNB 244.
96 Day 96, p.58.
97 SNB 692.

bedroom, and to reduce embarrassment got them up earlier than the others so that they could take their sheets to the laundry and shower.[98] Sr Brenda said:

> "As the Sisters cared for a number of children from a number of various backgrounds, it may have been difficult for them to consider the individual needs of each child. The reason behind a child's bedwetting was clearly not dealt with appropriately and methods used to prevent bedwetting were not well known at this time. Medical advice was later sought by the Congregation to help the children and the Congregation do accept that their methods were not acceptable."[99]
>
> "The requirement that a child carry their wet sheets and pyjamas to a laundry collection point was clearly a source of embarrassment and humiliation and ought not to have occurred."[100]

51 Although the Congregation disputed the witnesses' evidence, we accept that it forms a consistent pattern showing that from the 1940s to the 1960s enuresis was treated primarily by punishment and humiliation. The use of the bell and pad system in the 1950s was progressive, but its effectiveness appears to have been undermined by the way in which the system was applied. If the outcome was a beating or other punishment, as well as waking other girls in the dormitory, the girls using the system would have been apprehensive. While some children require medical help, many cease to wet their beds when they relax, feeling cared for and safe at night. **The punitive approaches described in the evidence would not have given the children any sense of security but would have added to their anxiety; the measures would have been ineffective in dealing with enuresis and constituted very poor childcare practice, amounting to systemic abuse.**

Health Care

52 The Congregation's evidence indicates that a GP was appointed as doctor to Nazareth House and he visited weekly, as well as undertaking the periodic examinations required by the Regulations. The evidence of witnesses suggests that on some occasions health matters were taken seriously and girls were taken to hospital, but at other times problems were not properly addressed, and the health care provided by the sisters was at times rudimentary.

98 Day 112, p.74.
99 SNB 2009.
100 SNB 1966.

Furthermore, four of the witnesses quoted below attributed life-long problems to the way they were treated at Nazareth House.

53 HIA 166 said that the doctor visited annually, but a nun always sat in on the examinations and the girls never complained, as the nuns would have given them a hiding for not speaking to them first.[101] SR 145 was responsible for the "work room" where the medicines were kept, but girls were afraid to attend in case she slapped them across the ear. As an example of the girls' reluctance to seek help, HIA 30 suffered a serious ear infection when she was thirteen but she was:

> "afraid to say anything because I didn't want to be accused of showing off and drawing attention to myself".

She told us that SR 134 gave her a clap on each ear in school one day and it took HIA 30 a minute to recover. From then on she had serious problems, ending up in inflammation and swelling which required a week's treatment in hospital.[102]

54 In the 1940s HIA 335 used to sleepwalk and she said that SR 177 strapped her into bed to stop her getting out at night, though the strapping appeared to have been removed during the night.[103] HIA 166 helped a girl who was feeling sick, but was blamed for disturbing others in the dormitory. In consequence a nun hit her, first with her hands, and then with a studded shoe, splitting her eyebrow open. She put a plaster and a bandage on HIA 166's eyebrow, and HIA 166 was not allowed in the classroom until the swelling had gone down in case visitors saw her. She was told to say that she had fallen out of bed and knocked her head on the bedside locker. HIA 166 was never seen by the doctor and the scar is still visible.[104]

55 HIA 430 said that a nail went through her leg when she slipped on a chair, and it took a long time to heal but she never saw a doctor during her time in the home.[105] HIA 166 got three splinters in her knee when scrubbing the babies' dormitory; she removed two, but the third became seriously infected and she spent two or three weeks in bed. The doctor prescribed a poultice and the sisters gathered round her bed to pray for her.[106]

101 SNB 291.
102 SNB 759-760.
103 SNB 024.
104 SNB 293-294.
105 SNB 805.
106 SNB 292.

56 HIA 234 said she fell off a climbing frame and was knocked out, but was not treated. From this time she started to suffer headaches and problems with her vision and balance. Eventually a brain tumour was diagnosed and it was removed at the Royal Victoria Hospital.[107] HIA 134 broke her arm, but she said it was three days before SR 199 believed her; she then saw a doctor and her arm had to be put in a cast.[108]

57 HIA 85 said that Jeyes fluid had got into her ear and her ear drum had burst, causing severe pain. She was taken to the Mater Hospital in Dublin, but they were not able to help, and it was only later in life that it was successfully treated.[109] When back in Nazareth House, HIA 85 told SR 145 about her ear, and she slapped the other one, saying "Now you have two sore ears."[110]

58 HIA 37 commented that when girls required care, such as taking up food to girls in bed with measles or dealing with head lice, the nuns always left this to the girls and they never exposed themselves to risk.[111]

59 In summary, there is no indication in the evidence that there was poor medical care once the health service had become involved. Perhaps because of the destruction of records, it is not possible to corroborate these allegations, but it is clear that the incidents described were significant to the witnesses, and the effects of some were still apparent in later life. **The home nursing described was very poor in terms of the failure to take some problems seriously, the rudimentary treatment given, the physical abuse on some occasions, and the lack of loving care for children who were unwell. This amounted to systemic abuse.**

Menstruation

60 The onset of menstruation was a traumatic time for several witnesses, as they had not been prepared for it and had no understanding of what was happening. HIA 117 said that when she had her first period she thought she had cut herself and that she was dying. She said she was put in a dark room and then brought out to the canteen and put in front of everyone to tell them she was a woman now.[112] HIA 62 said she was unaware that she was having her first period when on the way to her first day at

107 SNB 331-332.
108 SNB 867.
109 SNB 264-265.
110 SNB 265.
111 SNB 058, Day 107, p.140.
112 SNB 875.

secondary school. She was taken back to the home and placed in the isolation room.[113] HIA 95 started periods early at the age of nine; nothing had been explained to her, she said in oral evidence, and so she did not know what was happening to her and found it frightening.[114]

61 Witnesses also criticised the sanitary equipment and way in which the sisters provided it. In the 1950s sanitary towels were made from sheets and each girl was given six with their names on them. If they did not wash them well enough, the laundry worker called the girl out in front of everyone.[115] Next they were provided with leather belts and thick pads, which they had to wash and re-use, drying them out under their mattresses.[116] HIA 95 said that sanitary towels were put in a box to be washed.[117] The re-use of pads was denied by the Order.[118]

62 Later, HIA 63 told us that the girls had to approach the nuns, and the sanitary towels were left under their pillows and limited to one for the day and one for night time, which was said to be never enough.[119] HIA 61 said that the limited availability of sanitary towels, which were rationed by the nuns, meant that the girls smelt awful at school and other girls commented that they smelt foul.[120]

63 The Sisters' failure to offer sex education was also criticised. HIA 30 said that the only sex education they got in the home was to marry a Catholic and keep the faith.[121] Girls were given a copy of *My Dear Daughter* to read.[122] HIA 63 said that the girls were told to say a prayer to Our Lady but were given no sex education at all, and anything they learned was from the older girls.[123] By contrast with the evidence of other witnesses, HIA 37 said that SR 116 used to talk to girls privately in her cell and go through *My Dear Daughter* with them.[124]

113 SNB 674.
114 Day 97, pp.46-47.
115 SNB 760.
116 SNB 205-206.
117 Day 97, pp.46 to 47.
118 SNB 2043.
119 SNB 685, 875.
120 SNB 768.
121 SNB 760.
122 SNB 674.
123 SNB 685.
124 Day 107, pp.138 and 139.

64 To put these practices into context, it should be noted that in society in general sex was a taboo subject in the earlier decades; women, for example, were still churched in the days before the Second Vatican Council in 1962-5.[125] As Sr Brenda put it, sex was "shunned as a bad thing".[126] It is understandable that the sisters were uncomfortable in dealing with it. Nonetheless, the Order had chosen to take on the task of caring for adolescent girls, and it was one of their responsibilities to prepare them for menarche, to deal with their physical needs sensitively, to explain to them what was happening and to help them to cope emotionally. The evidence demonstrates that the nuns clearly failed as far as the witnesses were concerned. When the staff was expanded to include lay workers, the girls' keyworkers were said to have undertaken this task.

Clothes

65 Witnesses made relatively few comments about clothing. They spoke of their own clothes being removed on admission, and of being given old clothes in the 1950s and 1960s. The children all wore hand-me-downs but HIA 316 said that they were given a new skirt every six months, and they had two jumpers, which were changed once a fortnight.[127] HIA 28 said that the nuns also made pinafore dresses for the girls.[128] HIA 9 considered the clothing satisfactory, though SR 122, who did all the sewing, smacked girls' heads if they ripped their aprons.[129]

66 Footwear presented problems for some. In the 1950s, shoes were handed out by older girls and the younger ones were frightened to complain, so that at times they ended up with shoes which were too tight.[130] HIA 316 said that they were given shoes at the start of winter.

67 HIA 250, who was at Nazareth House throughout the 1960s, said that each child had her own toiletry bag with her own toothbrush and toothpaste, and she brought her bag to show the Panel.[131]

125 Churching was a ceremony in which a mother was blessed following the delivery of a baby; it included purification and a woman who had not been churched was considered unclean.
126 Day 119, p.17.
127 SNB 831-832.
128 SNB 043.
129 SNB 002.
130 SNB 181.
131 SNB 819, Day 100, p.23.

68 A concern for some witnesses was that they felt that they were distinguishable from the day pupils when at school. The Congregation made sure that the girls all had the necessary school uniforms when at secondary school off the premises. At St Monica's School, which was attended by the majority of the girls, they all wore the standard uniform, but HIA 327 said that the home girls still stood out because they had bowl haircuts.[132]

69 In the later years, children were consulted and allowed to choose their own clothes within a budget.[133]

70 Because the home had to rely on inadequate income in the earlier decades it is understandable that the Sisters had to rely on donations of clothing. Many people in the wider community would have passed on clothes from older children to younger ones, so that hand-me-downs were considered acceptable. The Order also augmented donations with clothing which was made in their workshop. The account of ill-fitting shoes described above was of course unacceptable. The main problem, however, is that if the Sisters had obtained per capita funding from the welfare authorities at an earlier stage the quality of clothing could have been significantly better, and children could have had more choice and individuality of style in the use of clothing grants.

Numbers and Names

71 HIA 32 was at Nazareth House in the 1930s and 1940s, when there were 160 girls in the home. They were "always called by a number", but on the odd occasion their names were used, which was how she found out she had two sisters in the home.[134] In the 1940s, HIA 439 said that the children were only known by numbers, not names, and if a nun wanted to speak to a child, she called out her number.[135] In the 1950s HIA 85 said that when she was called out to be publicly punished her number was used.[136]

72 HIA 61 was at Nazareth House in the 1960s:

> "We were all given numbers which the nuns would use to identify us, but at a later stage they started to use our surnames."[137]

132 SNB 797.
133 SNB 1968.
134 SNB 234.
135 SNB 204, Day 93, pp.29 and 30.
136 SNB 268.
137 SNB 767.

HIA 161 said that in the 1960s surnames were used to call the girls, rather than first names.[138] HIA 171 said that in the late 1950s and 1960s their numbers were printed on their clothes, which was embarrassing outside the home. At school they were called by their numbers as well as their names, which annoyed her.[139]

73 The Congregation denied that children were known by numbers and not by their names;[140] they have stated that there was no policy about the use of names and numbers, and there was no point at which it was decided to abandon the numbers. They saw this as a purely practical matter, to help with the organisation of clothing. From the evidence, we accept that numbers were used for a number of purposes in the earlier decades, but possibly only for laundry during the period covering the majority of the witnesses. In a large home such as Nazareth House, using such a system was certainly preferable to having a common pool of clothing. In so far as numbers continued to be used for other purposes, this would have been unacceptable.

Food

74 A number of witnesses commented on the poor quality of the food from the 1930s to the 1960s, presenting a fairly consistent picture throughout. HIA 32, for example, said that food in the 1930s and 1940s was not great and the girls were often hungry, with cocoa and a round of bread dipped in lard for breakfast, a potato and stewed onions for lunch, and lumpy porridge for tea. She said that they ate the slops from the nursing home, ate raw turnip skins and stole sweets and fruit. The washerwoman, NHB 35, caught her taking pears and apples for the other girls, and she said she was still scarred on her thigh from the nails in the plank with which NHB 35 hit her.[141]

75 One of the main targets for criticism was the meat - "usually bits of fat" according to HIA 361, "lumpy fatty stew" said HIA 387, and "sausages full of gristle" according to HIA 43.[142] HIA 103 said "The stew was water with bits of grizzled fat in it".[143] On one occasion, when the girls were due to go on holiday to Glenariff, they were served mutton stew which had gone

138 SNB 146.
139 SNB 780.
140 SNB 1968.
141 SNB 236.
142 SNB 713.
143 SNB 072.

off, but the nuns threatened that they would not go on holiday if it was not eaten. HIA 37 said that despite the smell and the consequent vomiting, the stew was eaten.[144]

76 Other items which were mentioned included lumpy porridge, "black boiled eggs", "pork pies that were just full of jelly and fat",[145] tapioca and greasy fried bread. References to eggs give an indication of the diet provided. HIA 30 was at the home during the later 1940s and 1950s.

> "My mother came from a farm and she used to send me up half a dozen eggs once a year or so. The nuns would single me out because of this and make sure I wasn't getting any ideas above my station just because I was getting a fried egg and nobody else was."[146]

HIA 361, who was at Nazareth House in the 1940s when rationing was in force, said she did not see an egg till she was ten or eleven years old.[147] HIA 439 was used to "good country food", but at Nazareth House it was only on Easter Sunday that they had a boiled egg.[148] HIA 316 said that on Christmas Day the girls were "so excited" because they had a fried egg.[149]

77 The food provided was contrasted with what others had, and in particular the nuns. The Congregation insisted that the nuns had the same food as the children, and if anything they ate less well so that the children had enough.[150] HIA 63 worked in the kitchen, however, and said that while the children's food ranged from acceptable to horrible, the nuns ate very well, having meat without fat and omelettes.[151] HIA 223 said that when she worked in the kitchen she could not believe what the nuns had to eat: meat, potatoes, vegetables, trifles and cakes.[152]

78 HIA 328 said that girls from the community attending school used to bring things which the home girls were not used to, and they had pocket money to spend in the tuckshop, which the home girls did not have. They never saw sweets, biscuits or crisps.[153]

144 SNB 056-057.
145 SNB 794.
146 SNB 755.
147 SNB 371.
148 SNB 206.
149 SNB 829-830.
150 SNB 2127.
151 SNB 683.
152 SNB 316, Day 95, pp.112 to 114.
153 SNB 361.

79 Several witnesses mentioned that they were hungry, including HIA 387, HIA 166, and HIA 103. HIA 327 wrote:

> "The food was terrible, but we were always hungry so we just had to eat it."[154]

The girls reacted in various ways. Bullies sent HIA 439 over the wall into the orchard to steal apples and pears, but she was caught and told off by Canon O'Neill.[155] HIA 52 said that once, during a nuns' retreat, a girl got hold of the keys and they raided the pantry. The girls never had luxury items such as cakes, and she was not the only witness to have claimed that the girls resorted to eating grass because of their hunger.[156]

80 Several witnesses commented on the nuns' insistence that they ate the food provided:

> "The nuns would walk up and down the tables and stand behind us, always watching to make sure we ate our meals."[157]

HIA 361 said that if food was not eaten, it reappeared at the next meal. If she tried to sneak it into the bin, the nun made her take it out and eat it, even if she was sick.[158] HIA 387, HIA 197 and HIA 439 also mentioned being made to stay at the table till food was eaten, or being forced to eat vomited food. HIA 298 was given a large lump of fat to eat and when she refused, a nun told her she could not leave the dining room until she had eaten it. A lay member of staff later took the plate from her and told her to go to bed.[159] HIA 124 said there was frequent force-feeding, with one nun pulling her hair back and holding her nose, while another put carrots in her mouth and held her chin till she swallowed them. HIA 124 believed that it was this force-feeding that caused her to develop anorexia later on.[160]

81 Some witnesses were less critical. HIA 316 said she could not remember starving: "the food wasn't great but it kept us alive."[161] Others criticised the diet as being bland and stodgy. It was only on feast days and at Christmas a bottle of HP sauce and a bowl of sugar would have been put on the table.[162]

154 SNB 794.
155 SNB 206.
156 SNB 810.
157 SNB 794.
158 SNB 371.
159 SNB 701.
160 SNB 839.
161 SNB 829-830.
162 SNB 794.

82 By the mid-1970s the food seems to have improved. The girls ate in smaller dining rooms in the groups, and by this time the per capita allowances should have enabled the Sisters to spend more on the children's food. SR 153 was at Nazareth House from 1970 to 1973 and she said that by that time the sisters ate with their groups of children; they had the same food and plenty to eat.[163] HIA 257, who was at Nazareth House in the late 1960s and early 1970s, said the food was good, with fruit and crisps, and jam and bread for the children to fill up on.[164]

83 In common with other aspects of the care provided by the Sisters, it seems clear that standards of food improved considerably over time. In the earlier decades, however, the volume of evidence provided by the witnesses indicates that the quality of the food provided fell below the acceptable. The number of complaints about the fatty stew suggests that butchers provided the home with the cheapest cuts of meat, which is unsurprising if the budget was tight and there were large numbers of girls to provide for. The rarity of eggs on the menu suggests a lack of variety in the menu. That the food was also insufficient is underlined by the stories of girls raiding the orchard and the pantry, and the number of complaints about hunger. If the Sisters had approached the welfare authorities for payments, some of these problems could have been avoided. We conclude that the standards of food at times fell below what should have been seen as the minimum in both quality and quantity. While the sisters' basic food may have been the same as the children's, we are not persuaded that they did not enjoy extras at times which were unavailable to the girls.

84 The Order denied that girls were force fed or that they were forced to eat unfinished meals.[165] However, seven of the witnesses reported undue pressure exerted on the girls by the nuns to eat food which they did not want to consume, though only one described being force-fed in detail. Most of these complaints related to individual girls, but on one occasion the whole group was threatened with the forfeiture of their holiday if they did not eat some rank mutton. The one instance of force-feeding is insufficient to be considered as systemic abuse, but we accept that the nuns did compel children to eat food, and this was very poor childcare practice, as the Sisters should have known at the time. It would not have persuaded the children to like or appreciate the food, but was perhaps

163 Day 112, p.71.
164 Day 100, p.83.
165 SNB 1967.

more a demonstration of authority, as the refusal of food can be seen in residential care as symbolic of rejection of the provider's parental role.

Activities

85 Witnesses did not comment much on the activities available during the evenings, weekends and holidays, but in general observations were positive. There were swings and climbing frames in the grounds, but HIA 328 felt they were only for show, so that people going past in buses would be impressed. She said that "there wasn't a toy or a book inside the convent", other than the Bible and prayer books.[166] HIA 327 said that television was allowed once a week, on Saturdays. Even on cold days they had to stay out in the garden until the bell rang, and she remembered freezing.[167] Children's activities in the units were limited to watching television and doing chores.[168]

86 HIA 257 was at Nazareth House till the mid-1970s, and by then the range of activities had expanded to include skipping, Irish dancing, violin and accordion classes, choir, ballet, elocution, swimming, cinema, walks with picnics, trips to museums or the beach.

> "There were always activities ongoing and the nuns supported us and encouraged us in whatever we were good at".[169]

Witnesses also mentioned drama lessons, scouts, girl guides and the availability of second-hand bikes to take trips.[170] Nor was it just a question of the range of activities:

> "As we got older we were granted a lot more freedom. The older girls could go out to dances and were given a key to get back into the house".[171]

87 A woman taught Irish dancing, and the children won lots of medals and cups.[172] HIA 39 found the dancing "an escape from the routine of the home", which she really enjoyed as the costumes were beautiful and they won cups and medals.[173] HIA 257 said that she herself was a champion

166 SNB 361.
167 SNB 793.
168 SNB 732
169 SNB 340.
170 SNB 824.
171 SNB 340.
172 SNB 831.
173 SNB 245.

Irish dancer, competitive in everything and encouraged to be the best.[174] HIA 103 was given the opportunity to learn the violin, taught by a music teacher from outside which she enjoyed.[175]

88 In the summer time all the children went on black taxi trips to Tyrella beach, with six or eight children to a taxi, which they enjoyed.[176] On one occasion in the 1940s the US Navy took the children to see a submarine.[177]

89 It appears from the evidence that in the earlier decades the girls were left to their own devices when playing outside, but that there was a range of occasional organised activities in which good use was made of volunteers, such as the Irish dancing classes and the summertime taxi trips to the seaside. From the mid-1970s a wider range of activities seems to have become available, perhaps in part because of the increases in staffing.

Birthdays

90 HIA 361 who was at Nazareth House in the 1940s and HIA 327 who was there in the 1960s both said that birthdays were never celebrated.[178] HIA 223 was born on Christmas Day, and she learnt that it was her birthday in 1958 when she was ten, when she was selected to put baby Jesus in the crib on the grounds that it was her birthday.[179]

91 The Congregation say that birthdays were celebrated, but this could have been from the 1970s onwards. Birthday celebrations are one of the most obvious ways of giving individual attention to children and their introduction would have been a significant (if delayed) milestone in the change from institutional to individual styles of care in the home.

Christmas

92 The girls were invited to parties, for example at Mackies' factory, but if they were given presents, witnesses said they were removed as soon as the girls returned to the home and they did not see them again.[180] Any sweets they were given were also taken from them on their return.[181] HIA 327 disliked Christmas parties as they made her feel like a charity case.

174 Day 100, p.84.
175 SNB 073.
176 SNB 185.
177 SNB 756.
178 SNB 796, 375.
179 SNB 319.
180 SNB 320.
181 SNB 756.

She saw her brothers at parties, but did not know they were her brothers and only got to know them on leaving care.[182]

93 Bishop Street Ceilidh Band from the Derry Nazareth House visited and put on a show.[183] HIA 55 said that being taken to the Christmas pantomime was her only good memory of Nazareth House.[184] HIA 28 said that shows were put on at Christmas, which was:

> "... the only time the nuns were good to you and you got a decent dinner. We might have got a pair of slippers in a Christmas box and maybe an apple and an orange. We thought that was brilliant; it was such a treat."[185]

94 HIA 55 was given a game called Smugglers, but it was taken off her the next day.[186] HIA 361 was given an orange and two sweets for Christmas; she wanted to savour the orange and kept it, but it went mouldy.[187] HIA 14 said that NHB 102, the handyman, dressed up as Santa Claus and handed out second-hand items which people had donated; she received an umbrella with holes in it.[188] They had to scrub the home if visitors were expected, smile and tell them everything was great.[189]

95 Christmas was clearly special to some of the children, but it also seems to have been a time of disappointment. It is hard to see why the Sisters would have removed toys and sweets from the girls, but in addition to the witnesses who were in Nazareth House it appears to have been a pattern in evidence from other homes run by the Order.

Education

96 The primary school was on site, and the nuns who taught the girls were also those who looked after them in their groups, which confused HIA 197. HIA 327 said there was no escape from SR 31, who ran their group before and after school and taught them as well, but she was not as harsh at school, in the presence of pupils from outside.[190] In the primary school there was a system for girls to have partners and they were responsible

182 SNB 795-796.
183 SNB 003.
184 SNB 195.
185 SNB 046.
186 Day 103, p.45.
187 SNB 375.
188 SNB 120.
189 SNB 046.
190 SNB 793.

for each others' clothes, shoes and hair, for example darning each others' socks.[191]

97 A number of witnesses were critical of the quality of education provided. According to HIA 166:

> "The education was very basic, there was no such thing as special attention, and rather those with difficulties were ignored or made an example of".[192]

It was said that in the class for backward children they spent their days in two groups divided by age, drawing, knitting or in silence.

98 Several witnesses spoke of being emotionally abused by being humiliated in class. HIA 32 hated her teacher, SR 112, because she was English:

> "[SR 112] made me spend a lot of time in the corner with a sheet of paper pinned to my back with either 'dunce' or 'thief' written on."

When SR 112 refused to let her go to the toilet she wet herself and SR 112 humiliated her by making her walk through all the classrooms to get a mop and bucket.[193] HIA 197 said that SR 134 mocked her in front of the whole class, undermining her self-confidence, and she put her academic underachievement down to fear, rather than stupidity. HIA 52 said she was called a dunce and made to stand in the corner with hands on head:

> "You were always put down and told you were good for nothing".[194]

99 HIA 361 wrote:

> "They didn't teach us anything other than religion. It was religion, morning, noon and night. There was constant praying. We had to pray when we woke up, before meals, after meals, at the start of school, and before we went to bed. When I later went to school in England, I couldn't believe how much I knew about religion. My hand was always up, but it was the only subject I knew. I could barely read and I couldn't count. I could write but I wasn't good at it. I couldn't tell the time".[195]

100 HIA 85 said that clever girls were picked out and sent to night school, but the nuns did not bother with the rest.[196] HIA 197 also noted that the nuns

191 SNB 372.
192 SNB 290.
193 SNB 235.
194 SNB 810.
195 SNB 372-3.
196 SNB 264.

took an interest in clever girls who were succeeding.[197] There appears to have been a selection process, with a small number of clever girls passing the 11-plus, the majority moving on to St Monica's secondary school and a few being transferred to a special school. HIA 14 found the education in general good and she passed the 11-plus.[198]

101 HIA 20 said she was labelled backward, and was sent to Immaculata School for the educationally subnormal after half term at St Monica's.[199] In oral evidence she said that the labelling had been damaging and had had a life-long impact, but later in life she nonetheless qualified as a nurse and wrote a book about her experiences.[200]

102 HIA 117 said that she was withdrawn from the 11-plus examination as she had a fit of nervous giggling. However, she added that all the girls, including herself, were sent to St Monica's Secondary School anyway.[201] HIA 63 said that SR 31 stopped her taking the 11-plus and kept her back.

> "The nuns never encouraged education. I believe if I had stayed in school longer and got some qualifications it would have been better for my career".[202]

It is possible that the withdrawal from the 11+ was due to a misunderstanding about HIA 63's age. HIA 195 felt she had the capability to do well academically, but SR 31 sent her to Oakwood special needs school, where she had a difficult time, being attacked by Protestant children.[203]

103 HIA 52 said that the girls were slapped, strapped and caned at St Monica's. After she had thrown a snowball at the head's house, HIA 52 was put on the stage, told she was the worst girl in the school and expelled, for which SR 116 gave her a hiding.[204] In oral evidence she said that girls from Nazareth House stood out at St Monica's both because of their clothes and because they did not know how to interact with other people.[205]

197 Day 95, p.15.
198 SNB 120.
199 SNB 184-185.
200 Day 107, pp.34-37, 53-54, 165-166.
201 SNB 875.
202 SNB 684.
203 SNB 175.
204 SNB 813.
205 Day 97, p.85.

104 The combined roles of teacher and head of a residential group in the home will have meant a very long working day for the sisters involved. They will have had very little time for leisure or the preparation of teaching materials. It is not surprising, therefore, that the picture painted by witnesses is of lack of stimulation and a punitive approach to discipline. While the quality of the education provided in the school is not a matter for this Inquiry the girls' experience of school is relevant because the school was in the same premises as the home, nuns worked in the home and the school and their approach to discipline and administration of punishment was similar in both settings. It could have been anticipated that many of the girls who were admitted to Nazareth House were under functioning educationally because of poor stimulation at home and unhappy early experiences of schooling. It was for the Sisters to compensate for these drawbacks by assessing the individual girls' needs and encouraging them and helping them to catch up through homework and study and achieve their potential. The evidence suggests that they fell short of these aims.

Family Contact

105 Some witnesses felt that in the earlier decades the Sisters deliberately kept siblings apart, but the Congregation denied this. There is evidence that siblings were introduced to each other, but this appears to have been occasional and insufficient to maintain family bonds. The instances recalled by witnesses indicate that such contacts were unusual, but all except one example relate to the period before the home admitted boys, which permitted families to remain together.

106 HIA 361 was at Nazareth Lodge in the 1940s; she never met her sister and did not know she had sisters and brothers; retrospectively she felt that they had been deliberately kept apart.[206]

107 HIA 28 and HIA 39 were two of three sisters who were together in Our Lady's group in the 1960s. HIA 39 was playing leapfrog in the playground one day in the yard with her two sisters, when SR 31 took them to the railings which separated the nursery from the girls' groups and introduced them to their youngest sister, who was in the nursery section. They rarely saw her after that until they left the home.[207] Previously they had not known that they had a sister in the nursery.[208]

206 SNB 376.
207 SNB 245.
208 SNB 043.

108 Once or twice a year the nuns arranged visits between Nazareth Lodge and Nazareth House, and in the 1950s HIA 95 was taken once to Nazareth Lodge where she managed to meet one of her brothers.[209] It was also on an organised visit that HIA 37 met her brother in the 1960s; she also met him once by chance at a pantomime.[210]

109 HIA 124 was at Nazareth House twice in the late 1960s and she alleged that her parents did not allow her to see her sister in hospital when she contracted leukaemia, and when her sister died HIA 124 was not permitted to attend the funeral.[211] The Order commented that they could not understand how this happened.[212]

110 Parents were able to visit when they chose, but usually called on the home at weekends. HIA 103 said that her father was never made to feel welcome by the nuns; he passed HIA 103 a bag of oranges over the wall and the sisters always asked for money when he visited.[213] HIA 103 said that he gave her an envelope each week to pass to the nuns.[214]

Confiscation of Possessions

111 We have already noted that on admission children were issued with clothing by the home and their own which they wore on arrival was removed. Mention was also made of toys given to children at Christmas being removed. The evidence of witnesses suggests that these were only two examples of a much more widespread practice whereby clothes, toys, presents, fruit and money were taken from children by nuns. Sometimes they were passed to other children; often they were never seen again by the witnesses.

112 Every Christmas HIA 161's mother sent a tea-chest full of dolls, clothes and selection boxes. It was the one time in the year that she and her sisters were called together, to see the contents, so that her elder sister could write to their mother to say that they had seen everything and to thank her. HIA 161 said that the nuns then took the dolls from them and said that the contents were going to a better cause.[215] The Order accepts that toys and presents might have been tidied up and put away, but not that they were maliciously taken from the children.[216]

209 SNB 665.
210 SNB 055.
211 SNB 840, 61457.
212 SNB 2093.
213 SNB 70-71.
214 Day 99, p.184.
215 SNB 148, Day 98, p.27.
216 SNB 2019.

113 HIA 375 said that her parents brought little presents and they were told to put them in their lockers, but the presents disappeared and HIA 375 said she would have known if other children had taken them.[217] HIA 103 gave examples of personal items which she alleged were taken by the nuns and disappeared - a yellow jumper bought for her by her father, a lambswool dress, and a doll called Rosebud which was given to her at a Christmas party. She believed that these items had been sold.[218] HIA 134 was financially supported by her stepfather, who sent her dolls and dresses, which she said she never received.[219]

114 HIA 95 said that when her father brought her sweets, the nuns took them.[220] HIA 327 said that dolls appeared when there were due to be visitors, and disappeared afterwards.

> "If a child came into the home with a toy, it was taken off them. The nuns seemed to enjoy being cruel".[221]

HIA 368 said that clothes bought for him and his sister by their social worker were also removed by the nuns as soon as they returned to Nazareth House and were never seen again. There is a record of the purchase of the clothes.[222] His sister tried to tell the social worker, but there is no record of a complaint being made.[223] HIA 14 stayed with her aunt and uncle in the holidays. The nuns took any presents she took back with her to the home, together with any clothes which her aunt had made - "We had nothing we could call our own".[224]

115 HIA 175 went to a football match with her sister, who entered her name in a competition, and a man arrived at the home with her prize, a football signed by the Down team, He presented it to her but she never saw it again.[225] A slide was donated to the home, as recorded in a photograph which includes the benefactor, but it was never seen again.[226] In oral evidence HIA 43 mentioned a newspaper cutting which alleged that the Order was selling clothing and toys at jamborees. She believed that her

217 SNB 734.
218 SNB 073.
219 SNB 866.
220 SNB 664.
221 SNB 796.
222 SNB 6446.
223 SNB 656-657.
224 SNB 120.
225 SNB 165.
226 SNB 716, 61969.

hair had also been cut and sold.[227] On the day of her First Communion HIA 124 and her sister were given money by a neighbour; they were going to spend it on something for the girls, but the nuns took it from them.[228] The Order stated that this was to keep the money safe.[229]

116 The Order was no doubt hard pressed to find sufficient funding, but some of these confiscations were of items of little value, that would not have produced significant income if sold. A possible justification could have been that children who did not receive presents might have felt deprived on seeing other children with new clothes or toys, but if so, it was for the Sisters to give them clothes or toys to compensate, not to deprive the fortunate children, making them all equally deprived. Indeed, the situation offered an opportunity for the nuns to indicate their concern for the more deprived children and so create closer relationships with them.

117 The approach adopted proved to be cruel and negative. Personal possessions are important to children in defining their individuality; the 1952 Home Office Guidance spoke of children's treasured possessions needing to be treated with respect.[230] Confiscating possessions as described by the witnesses was a depersonalising institutional process. It was also emotionally abusive, as children lost precious items which reminded them of home links, such as the yellow teddy-bear jumper which HIA 43 was given by her father, and which disappeared - "the only reminder I had that somebody cared for me", as she put it in evidence.[231] Today such confiscation would be considered theft. **There was no valid childcare justification for confiscating the children's personal possessions, and this constituted systemic abuse.**

Foster Care

118 Every Sunday people from outside used to walk round the garden and identify children they wished to consider for a foster placement. Any child who was identified had to wash their face and go to the parlour to discuss the possible placement. HIA 62 irritated SR 134 because she wished to remain in the home and be with her sisters, and did not want to be picked.[232]

227 SNB 32995.
228 SNB 840.
229 SNB 2093.
230 HIA 472.
231 SNB 712, Day 96, pp.143-145.
232 SNB 674-675.

119 HIA 270 wrote:

> "On most Sundays we were dressed up and lined up for people to come look and take us out for the day if they chose us. I was chosen once… We were taken to a caravan and we were playing ball and I burned myself so the young couple panicked and we ended up in Casualty, I didn't seem to get taken out after that."

Fortunately for HIA 270, she formed a strong relationship with a member of staff whose brother and sister-in-law fostered her, and this became a long-term supportive relationship. HIA 270 was of mixed race, and a nun advised her foster-mother to pick a nice blond-haired blue-eyed child instead, but she refused firmly.[233]

120 HIA 124 went to stay for weekends with a policeman and his family, but when she returned, any presents such as sweets or a teddy were taken from her.[234] The girls were also sent to stay with families during the holidays. HIA 95 said that she was sent to a family with a newborn baby and she was supposed to help look after it. However the father of the family "tried it on" with HIA 95 during the night, and when HIA 95 resisted he drove her back to Nazareth House, saying that she was not doing the job she was sent to do.[235]

121 The idea of parading children for selection by potential foster parents would now be considered institutional and abhorrent, but the system appears to have resulted in successful placements according to witnesses in other homes, and it was commendable that the Sisters attempted to give children an experience of family life, with the possibility of long-term fostering and adoption.

Work Experience, Discharge and Aftercare

122 A number of girls were sent to Australia from Nazareth House under the child migrant scheme. Their evidence is dealt with in Chapter 6.

123 For children who stayed at Nazareth House till school leaving age, the Sisters found accommodation and employment. It appears that there was little preparation for discharge, and girls were not consulted about what they wanted to do. The jobs to which they were allocated were often poorly paid and menial. In the later years, there was independence training and aftercare practice was improved.

233 SNB 347.
234 SNB 838.
235 SNB 664-665.

124 HIA 439 was sent to work at St John of God Hospital in Newry, but she walked out the next day and contacted Fr Jeffrey who got her a job working with Rev and Mrs Cupples. She said they were brilliant, as this was her first experience of real family life, and the placement was an interesting example of interdenominational co-operation, as they were Presbyterians.[236]

125 HIA 328 left Nazareth House in 1970. The nuns told her "out of the blue" that she was going and gave her a suitcase and a set of clothes. She was not allowed to say goodbye to her younger sisters, and she was taken home to her mother's house.

> "Everything was strange. It was awful. I didn't know how to get a bus or ask for anything in a shop. They didn't prepare us for the outside world at all."[237]

She felt that after leaving, girls were not welcome to return.[238]

126 HIA 171 was exploited by her first employer who gave her £4 for three months' work, cleaning and baby-minding for long hours.[239] HIA 20 was told to collect a suitcase and take it to the parlour, where she met a lady who took her to a family where she was expected to act as skivvy. She was not prepared for the outside world and no one visited to check how she was getting on.[240]

127 When no outside employment or accommodation could be arranged, girls sometimes stayed on at Nazareth House. When HIA 316 left school she was told that she was to work in the old people's home at Nazareth House. This entailed laying out dead bodies, which petrified her.[241] The Congregation denied that at the age of fifteen HIA 316 would have been required to lay out dead bodies.[242]

128 HIA 52 also worked for the nuns in the old people's home and in the kitchen from the age of fifteen to eighteen, and she said that she was not paid.[243] The Order stated that HIA 52 would have been paid, but that money would have been deducted for her keep.[244] HIA 9 obtained a job

236 SNB 208.
237 SNB 365.
238 SNB 363.
239 SNB 786.
240 SNB 187.
241 SNB 833.
242 SNB 2144.
243 SNB 814.
244 SNB 2140.

stitching clothes when she left school at fifteen, but she also alleged that SR 31 took all her wages to pay for her keep at Nazareth House.[245]

129 HIA 62 complained that the preparation for her discharge was inadequate, especially in view of her upbringing in an insular environment. She left Nazareth House in 1974 during the Troubles, following an incident in which she and two others went to a disco without permission; she was placed by her social worker in a Protestant hostel, which put her at some risk.[246]

Religion

130 Religious observance was taken seriously. A chaplain was nominated by the bishop, but paid a weekly stipend of £5 by the Sisters. He said Mass every morning and Rosary and Benediction several days a week, he heard the girls' confessions monthly, and he prepared them for First Communion and Confirmation, though these services were held in the parish church.[247] First Communion and Confirmation were seen as special days, and HIA 335 said that in the 1940s the girls wore white and were allowed to ride on trams. People gave them sweets and pennies.[248]

131 HIA 316 said that the girls attended Mass every morning, and said Rosary and Benedictions throughout the day.[249] In the 1960s the three groups took turns to attend Mass.[250] It appears that in the 1970s there was a degree of choice and some girls chose not to attend, but they were exceptional and risked being labelled pagans by SR 31.

132 Misbehaviour in the chapel was treated as a serious misdemeanour. For example, when bullies pressured HIA 439 into making a joke confession, NHB 34 slapped her and took her into the chapel to kneel at the altar rail. Benediction was being held, and she said that the nuns shook their fists at her.[251] One priest slapped girls' faces if they did not say amen in a loud voice, according to HIA 161 and children who did not know their catechism were caned or whipped[252] or "whacked over the ear or hit across the hands with an implement".[253] SR 116 grabbed girls by the hair if not kneeling upright when praying. HIA 28 said that they had to kneel

245 SNB 005.
246 SNB 678.
247 SNB 80076-80077.
248 SNB 025.
249 SNB 829.
250 SNB 010.
251 SNB 207.
252 SNB 146.
253 SNB 025.

on the sitting room floor in their bare legs for half-an-hour prayers in the evening.[254] When she was about to make her Holy Communion, the nuns discovered that HIA 161 had not been baptised, and she said she was punched, kicked and put in another room away from everybody because she was deemed a pagan.[255]

133 There were occasional retreats, during which the children were not allowed to speak for three days, and they filled their time with reading or knitting. When caught talking, HIA 28 said, she was beaten on the hands and made to kneel and pray for three hours.[256]

134 Since the old people's home was part of the premises, HIA 328 saw dead bodies in a room near the chapel which she found "quite disturbing". She said that the girls were lined up on one occasion to kiss a dead nun, and as she was too small to reach she had to be lifted up.[257] About 1961 a girl making her way back from a foster home got lost in the snow and died. HIA 20 saw her in her coffin and thought she was asleep.[258]

135 HIA 234's conclusion was that:

> "Religion was drilled into us. I was on my knees all the time".[259]

HIA 234 was, however, the only witness to offer this criticism. In our opinion the level of observance was consistent with what might reasonably have been expected at that time in a home run by a Catholic Order.

Records and Care Planning

136 It seems likely that in the earlier decades records were rudimentary, and former residents seeking information have sometimes obtained little beyond their dates of birth, baptism and confirmation, admission and discharge, together with notes of any contact maintained after their discharge. When in 1964 at the age of eleven HIA 250 wanted to know more about her parentage, SR 31 gave her the details of her background.[260] Although there is no record that documentation has been destroyed, it seems likely that with the closure of the home, and in the absence of premises to store such material, most of it no longer exists.[261]

254 SNB 044.
255 SNB 146.
256 SNB 044.
257 SNB 359.
258 SNB 184.
259 SNB 330.
260 SNB 823.
261 SNB 1970.

137 By the mid-1970s more attention was being paid to the planning of the care and education of individual girls. HIA 257, for example, was assessed by a psychologist because of her temper tantrums, and she was shown considerable tolerance at school so that she did not have to be transferred elsewhere.[262] HIA 195 said that SR 31 sat in when they met social workers - "We weren't allowed to tell them anything".[263]

Staffing

138 The community in Nazareth House Belfast was made up of a group of sisters whose responsibilities were allocated annually.[264] Some were fund-raisers and travelled round the community to obtain money. Some were responsible for specific practical duties such as cooking or overseeing the laundry or chapel. There was also often a small number of retired nuns. For the early decades there was one sister per group of girls, about four in all, who were accountable to the Mother Superior. The Order accepted that these staffing levels were inadequate.[265] As noted in the section above on education, some of the sisters also acted as teachers, though this practice ceased in the later years. The nursery had a separate team of a sister and some helpers. In the early years before paid lay staff were appointed, the staff who were not sisters were "mostly old girls who had been out in service and could not settle, or had not the ability to survive outside", and they helped in the kitchen and laundry.[266]

139 It was probably in the late 1950s or 1960s that the sisters were first augmented by the appointment of lay staff who were often young single women, only a little older than the teenage girls whom they were supervising. The appointments were made by the Sister Superior.[267]

140 From the 1970s onwards, staffing levels improved and the size of the groups was reduced, so that the ratio of staff to children was more generous. Along with improvements in staffing levels, training for staff was improved. They were seconded on qualifying courses, and by the time that the home closed, a high proportion were qualified.

262 SNB 341,342.
263 SNB 175.
264 SNB 10399-10468.
265 SNB 1965.
266 SNB 16198.
267 SNB 1964.

Childcare

141 In this section we shall draw together our overall conclusions about the quality of residential childcare provided at Nazareth House, based on the evidence in the sections above on different aspects of daily living.

142 A number of witnesses were highly critical of the overall quality of childcare that they experienced HIA 55 said that the nuns were "physically and emotionally cruel" to the girls, and showed "no warmth or affection".[268] This was echoed by HIA 361 who said:

> "They never taught us anything positive. They just criticised us over everything. There was no affection or praise."[269]

143 A number of witnesses said that it was not simply a question of the nuns displaying a lack of affection, but that they discouraged girls forming relationships with friends or family members. HIA 37 said that "The nuns never showed any compassion or nurturing", but went on to state "They even discouraged affection between families".[270] HIA 27 said:

> "We had no real opportunity to make friends in the home as the nuns did not like us talking to each other".[271]

HIA 361 wrote:

> "I was always a loner. ...I used to stand in the corner. I didn't want anyone to notice me, particularly the nuns. ...I knew that if the nuns paid no attention to me, I wouldn't get slapped".[272]

144 It should be noted that three of the four witnesses quoted above were in the home in the 1940s and one in the 1950s. During the lifetime of Nazareth House standards of childcare improved greatly. Staffing levels were increased. Staff training was introduced. Physical conditions were better. The size of groups was reduced, together with the overall number of children. Boys were admitted, so that siblings could stay together. Recording, care planning and the involvement of children in decision-making were all introduced. These changes were not all made at once, but in the final years the quality of childcare was acceptable, and the only serious criticism was that the children were still housed in a large old institution.

268 SNB 194.
269 SNB 374-375.
270 SNB 058.
271 SNB 124.
272 SNB 372.

145 During the latter years there were fewer grounds for complaint, therefore, and this is reflected in the lower number of witnesses who were in the home then. The majority of the witnesses were in the home in the late 1940s, 1950s, 1960s and early 1970s, and our observations on childcare essentially relate to those decades. Those who were in the home before the Second World War or early 1940s gave similar evidence and made similar complaints, but they are fewer in number.

146 Residential childcare is difficult and demanding, especially if the children have suffered disturbed backgrounds and have to come to terms with unhappy and damaging experiences. Success requires a united staff team with shared values and aims. In this respect the community will have been a great support to the sisters responsible for the groups in Nazareth House, in helping them maintain their motivation in the face of very limited resources and unremittingly long hours of work, year in year out. The beliefs which they held in common and the vows which they had all made will have sustained them in their lifetime commitment to be of service.

147 It is possible, however, that some of the problems encountered in the evidence reflected the other side of the same coin. The Order was highly hierarchical; sisters were expected to be obedient, and would not have readily challenged the existing way of doing things. Indeed, they were directed to work where the Order required them. Until training was introduced they were not exposed to new ideas in childcare, and they therefore maintained - and did not challenge - methods which were decades out of date. Even in the later years the split between the sisters in charge of the groups and the lay staff whom they managed introduced a sort of class system which some lay staff resented and which detracted from teamwork.

148 For adults who voluntarily submitted themselves to be members of the Congregation, obedience will have reflected their life-long commitment, but if it was then expected of disturbed adolescents, there was a real risk of confrontations.[273] The main response of the sisters to any girl who was bold or cheeky appears to have been punishment, usually physical, but often involving humiliation. To help such children overcome their difficulties a much more tolerant and understanding approach was required, involving much more individual attention and discussion of the issues in question.

273 SNB 48751.

149 The sisters had given up much in becoming postulants, novices and then full members of the Order. They presumably had very few private possessions. Their lifestyle was modest – despite the allegations by some witnesses that they had better food than the children. Their contacts with their own families were severely limited. It is possible, then, that they did not appreciate how significant some possessions were to children or that they thought that children should not become attached to material possessions. Whatever the thinking, it is clear from the evidence that many witnesses bitterly resented having to give up clothes, toys or teddies on admission or after visits to their families or foster carers. While the sisters may voluntarily have chosen self-abnegation, the children had made no such choice.

150 A number of the witnesses observed that the nuns did not want them to make friends, sometimes separating girls who had formed friendships or warning other girls not to associate with them. Similarly, some witnesses had the impression that the nuns wished to split families. Although the Sisters say that they had no policy to break up families, there were few attempts to help siblings to maintain contact in the earlier decades, and the absence of frequent contacts often created life-long rifts. This was in the context of the Northern Ireland community, where family and extended family links were of great importance. The reasons for taking such a negative approach to family links, which was contrary to childcare thinking at the time, are hard to fathom, but the sisters themselves were expected to avoid developing close relationships which might harm the general wellbeing of their community, and it is possible that they applied this concept to the children.

151 The Sisters appear also to have feared that parents whom they saw as immoral or feckless would influence their daughters, and that the unacceptable characteristics of the parents would be replicated by the children. This is understandable, but the use of severe punishments or humiliation will not have been effective in countering the problem. HIA 161, for example, was in St Anne's group with SR 116, who, she said, beat her the most.

> "We came from bad people, bad homes, we were the scum of the earth, children of drunks and prostitutes and goodness knows what, and so we had our parents' sins to answer for, and that had to be beaten out of us".[274]

274 SNB 150.

The children needed to be loved and offered a more attractive way of living.

152 Sex education must have presented particular problems for the sisters. The childcare task at Nazareth House was to help adolescent girls learn how to relate to the opposite sex with a view to the roles they might fulfil as partners and parents. Having usually been members of the Order all their adult lives and taken a vow of chastity, the nuns presumably found their own life experience of limited help in this respect. Moreover, they appear to have equated sex with sin, and anything connected with sex was seen as abhorrent. This was apparent in the lack of preparation of girls for menarche; they were generally given the booklet *My Dear Daughter* to read and it was left to older girls to explain about periods. The system for handling menstruation was also punitive.

153 As noted above, the quality of childcare changed overtime. Systems became more flexible. The introduction of lay staff brought new perspectives on preparing girls for adulthood. Perhaps most importantly, the increases in staffing levels meant that children could have greater individual attention, and there would have been time for things to be discussed.

154 We have already concluded that the treatment of bedwetting, poor home nursing and the confiscation of the children's possessions were all systemically abusive. **However, during the earlier decades, the combination of aspects of childcare (such as excessive chores, an institutional approach to bathing, the use of Jeyes fluid, the handling of menstruation and sex education, the poor quality of food, the insistence on eating unwanted food, the failure to celebrate birthdays, the poor quality of education at the school on the premises and the failure to prepare children for discharge) which were all below the standard of childcare that might reasonably have been expected at that time, we consider that this amounted to systemic abuse.**

Allegations of Abuse

Physical Abuse by Staff

155 Over the years covered by the Inquiry, allegations of physical abuse were made against a number of nuns and lay staff. However, the bulk of the allegations relate to four sisters, SR 189, SR 31, SR 134 and SR 116. SR 189 was Principal of the school in the 1950s. The three last named

were each responsible for one of the three groups of girls and their time at Nazareth House overlapped for most of the 1960s. The three were all firm disciplinarians, and shared a common approach to childcare, such that they dominated the atmosphere in the home at that time. During the overlap there were typically over 20 girls at any one time in Nazareth House who have approached this Inquiry as witnesses. It is unlikely that there were more than forty girls in residence during this decade, and so the applicants will have formed an unusually high proportion of the total number of residents. Once the four sisters had left, in 1970, only two children were admitted in the following fourteen years who have made allegations of abuse to the Inquiry. The four sisters are considered individually below, following examples of evidence of physical abuse relating to other staff.

156 In the 1940s, HIA 439 considered the Mother Superior, SR 112, "very bad to us", as "she battered us stupid", using her cane, which she kept hanging from her belt, and hitting HIA 439 on her feet.[275] If girls refused communion, they were caned, and if they pulled their hands away when being caned, they were hit on their legs.[276] HIA 335 also said that SR 112 and SR 177 used a belt, a thick leather strap or a ruler to beat her.[277]

157 In the 1950s some of the punishments were inflicted formally in the presence of all the girls. HIA 95 said that NHB 42:

> "... was paralysed down one side and the nuns brought her up to the stage in the big hall, bent her over and beat her on her bare backside in front of one hundred girls. She couldn't even fight back."[278]

HIA 20 recalled a similar occasion when three girls were taken up onto the stage and were smacked on their bare bottoms in front of the rest of the girls,[279] and HIA 37 recalled this incident, saying that:

> "...the nun went at them and whipped them with a cane over and over. They did this in front of everybody else and listening to the screams of the girls was terrible."[280]

On another occasion NHB 51, was caned in public and HIA 37 said that she "counted each slap and I remember stopping at 100 because it was

275 SNB 204.
276 Day 93, pp.7-9.
277 SNB 024.
278 SNB 662.
279 SNB 183.
280 SNB 061.

so distressing."[281] HIA 85 explained from personal experience how she was told to lie down on the stage, with one nun holding both her legs in the air, whilst another nun hit her repeatedly across the bottom with a stick, a hairbrush or whatever implement they could get their hands on. She said it happened to her once and she saw it happen to other girls on numerous occasions. She considered it degrading.[282]

158 The Congregation pointed out that corporal punishment was widely used in families, schools and homes[283] but conceded that:

> "…with regret, the Sisters believe that the policy of 'no physical punishment' may not have been adhered to."[284]

Such punishments were contrary to good childcare practice, the Order's policies and the statutory 1952 Regulations for voluntary homes. Regulation 11(3) explicitly stated that caning should not exceed six strokes, that no caning should be administered in the presence of another child, and that children with known physical or mental disabilities should not be subject to corporal punishment without the sanction of the medical officer.[285] In the absence of records it is not possible to determine whether the last requirement was met or whether the punishments were recorded as required. **These formal corporal punishments constituted systemic abuse.**

159 Other physical punishments in the 1950s were informal. HIA 30 said the last beating which she received was from SR 190 when she was aged 15:

> "Her eyes were blazing with rage and she lunged at me".[286]

HIA 166 was hit for dropping the nuns' wimples in the mud. SR 145 said she was a child of the devil and battered her with a stick in the workroom.[287] HIA 387 summarised the maltreatment she experienced: being "slapped around the head and the back of the neck", "hit … on both sides of our hands with a ruler, until our hands bled", "punched most days for something or other", picked up "by the ears", and "hit with leather belts."[288] HIA 234 said that when she was seven or eight years old, while

281 SNB 061.
282 SNB 268.
283 SNB 2024.
284 SNB 2116.
285 HIA 290.
286 SNB 758.
287 SNB 294-295.
288 SNB 386.

on the way to the bathroom, SR 183 pulled her out of line, threw her onto the stairs, pulled up her petticoat and hit her hard in the stomach repeatedly with her fist. She found this upsetting as she said she had no idea why the nun did this.[289]

160 Further allegations of informal physical punishments were made by witnesses who were at the home in the 1960s. One of HIA 62's earliest memories was that when she was aged three or four she was knocked out by SR 180 by banging her head on a radiator for looking at the contents of her handkerchief after sneezing; she woke up in the isolation room.[290] This is one of the few allegations relating to the nursery.

161 HIA 62 also said she witnessed girls being assaulted, the worst being when her sister had her head banged against white tiles for not washing properly. She recalled that there was "blood all over the white tiles", and her sister suffered hearing problems thereafter.[291]

162 HIA 103 wrote that if the girls were carrying on:

> "…the nuns would come down shouting and roaring and would often thump you on the head with a bunch of keys or their fists. The nuns used to grab us by the hair on the side of our heads when we were being disciplined. They would also use a pointer cane on occasion or their fists if you did anything wrong."[292]

Witnesses also complained about physical abuse by lay staff. NHB 32 was an older girl who worked at Nazareth House in the laundry; HIA 14 said that NHB 32 pulled her hair and hit her round the head if she did not do the laundry correctly.[293]

163 HIA 14 said:

> "We just took the beatings and said nothing. There was no one to tell and no one would have believed us. Nobody would have believed that the nuns would have been capable of treating children that way. We also did not know any better and didn't fully appreciate at the time how wrong it was."[294]

289 SNB 331.
290 SNB 670.
291 SNB 671.
292 SNB 071.
293 SNB 119.
294 SNB 118.

164 As HIA 28 pointed out, many children, whom she termed the "goody-goodies", were not hit. Punishment was for those who stepped out of line, and they were clipped for not dusting under their beds properly, or making their beds or not doing the cleaning. Sometimes they were taken to the sewing room on the ground floor near the changing room to be hit.[295]

165 Other punishments were applied in addition to beatings. SR 122, for example, was said to use Jeyes fluid as a punishment and bathed sores with it.[296] When HIA 171 used a de luxe soap which she had been given at a Christmas party, a nun accused her of being vain, and made her kneel outside her cell.[297] For running away, girls were made to kneel outside the nuns' cells and then scrub the passage the following day.[298]

166 There was only one example of a group punishment. According to HIA 20 some girls went out onto the fire escape to watch a firework display. SR 134 punished them by making them kneel all night with their hands behind their heads. Girls in other groups had to spend the night on the fire escape.[299]

167 HIA 197 said:

> "It seemed to me that the girls who didn't have any family always got it hardest from the nuns, probably because they had no one to turn to. We were also punished more often than the children who had family come in to see them. They were very harsh on us, and slapped and picked on us for very minor things. They were always crushing us. I believe the nuns knew they had to be more careful and they couldn't be as hard on the girls with families in case they were caught out".[300]

This was not only a question of physical abuse; HIA 197 thought that girls with families also had lighter chores, dusting instead of scrubbing.[301]

168 By contrast, HIA 43 thought that the children who had been at Nazareth House since birth formed a clique and were treated better.[302] She thought that the nuns were aware of each other's punishment of the children and said that there was a general atmosphere of fear.[303]

295 Day 108, pp.61 to 63.
296 SNB 071.
297 SNB 783.
298 SNB 784.
299 SNB 184.
300 SNB 692.
301 SNB 693-694.
302 SNB 715.
303 SNB 693-694.

169 HIA 37 said:

> "I always thought they [the nuns] were very creative in their punishments actually. I mean, I have been brought up at home and I was chastised by my mother and father but never to the extreme cruel methods that they used".[304]
>
> "We would be told to kneel and to be caned as this gave extra force to the strikes. The nuns would use both hands for extra strength and cane us until they were exhausted."[305]
>
> "You had so many punishments…so bad it's like they all merged into one big black nightmare".[306]

170 It should be noted that of the thirteen witnesses quoted in this section, three were admitted to Nazareth House in the 1940s, six in the 1950s and three in the 1960s. Only one was admitted in the 1970s. The single witness to complain about punishment in the 1970s was HIA 25, who said that he tried to escape at every opportunity. On his return, his shoes were removed till he had to go to school, and he was punished with a beating for doing so every time. On one occasion he and his sister were put in a dark room, where a nun hit them with a broom. HIA 25 had lost both his parents in the previous couple of months and he was desperate to be with his siblings. He felt that the nuns should have understood this but they never sought an explanation.[307]

171 SR 153 said that it was for individual sisters to decide how to run their groups and she had no idea what other sisters did. No one explicitly said that caning was wrong, but only sisters were allowed to hit children. She said that in her unit when children misbehaved she usually punished children by stopping them from watching television, but even then she often relented and talked to them instead.[308]

SR 189

172 SR 189 entered the Congregation in 1939 and died about 2004. She was at Nazareth Lodge from 1945 to 1948 but then transferred to Nazareth House from 1948 to 1959, and it is to the latter period that the allegations made by witnesses refer. In 1976 at a General Chapter, SR 189 was

304 Day 107, p.144.
305 Day 107, p.144.
306 Day 107, p.146.
307 SNB 612-613.
308 Day 112, pp.82 to 83, 159 to 160.

elected as Superior General of the Congregation and she served for twelve years in this ministry.[309]

173 SR 189 was clearly highly thought of within the Order. Sr Teresa Walsh wrote:

> "[SR 189] although strict was very straight and direct and was not afraid to confront or challenge a person when appropriate. Sister was an extremely hard worker and would not suffer fools gladly. She was a formidable lady but had a good sense of humour."

The Order denied the more serious allegations made against SR 189, while accepting that she might have used corporal punishment.[310]

174 Witnesses made a wide variety of allegations against SR 189. HIA 95 considered her "a rough wicked woman", and the worst of the nuns. She belted the girls and grabbed them so tightly under the arm that she caused bruises. HIA 95 thought that SR 189 took against her because she was feisty.[311] HIA 30 said SR 189 threatened her and two friends that she would put the three of them in a sack and bury them in a hole because they were bold. HIA 30 said she believed SR 189 because they never doubted anything the nuns said.[312]

175 HIA 166 said that SR 189 caned her for an incident in the chapel, and that she also scrubbed HIA 166's neck with a scrubbing brush till it was raw and bleeding to get rid of sunburn.[313] According to HIA 161, SR 189 was vicious, smacking girls' heads on the wall. When she bled, she was told to clean it up.[314] HIA 85 made the same allegation:

> "Quite regularly when playing out in the garden, we would be subjected to having our heads banged repeatedly by the nuns against a red-brick wall. On one particular day [SR 189] was banging my head against the wall so severely that [SR 134] announced that she thought I had had enough and [SR 189] stopped."[315]

176 The Order did not accept that a child would be subjected to this treatment.[316] It is no doubt hard to accept that someone who has held high office in the

309 SNB 661,1907.
310 SNB 1907.
311 SNB 661-662.
312 SNB 757.
313 SNB 294-295.
314 SNB 150.
315 SNB 266.
316 SNB 1975.

Order could also have inflicted the type of cruelty which has been alleged. As the person in charge of the home, SR 189 will have seen herself as being responsible for maintaining overall control, particularly in dealing with bold or feisty girls, but that does not excuse breaches of the Order's policies and the Regulations. We accept that SR 189 not only inflicted formal punishments which breached the Regulations, but also informal physical punishments.

SR 31

177 SR 31 was responsible for Our Lady's group on the top floor. She was also in charge of the school at Nazareth House, and later the school at Ravenhill Road. She was at Nazareth House from 1959 to 1970. In addition to the witnesses who made allegations to the Inquiry, 36 people complained to the police about her conduct.[317] The evidence below includes accounts of both physical and emotional abuse.

178 Like SR 189, SR 31 was reported to have beaten children in public. HIA 117 ran away. The police picked her up and took her back to Nazareth House. HIA 117 said that after they had left, SR 31 stripped her, placed her on the stage and beat her in front of all the other children as a punishment for running away. SR 31 used some black sticks which were kept in a container. HIA 117 said that she was also belted and hit with rosary beads that night.

179 For informal punishments, SR 31 was said to have used a variety of instruments. According to HIA 117, SR 31 had a practice of knocking her on the head with her knuckles.[318] HIA 29 said that SR 31 hit her over the head with her keys.[319] HIA 327 wrote:

> "[SR 31] had a massive bunch of keys, like jailer's keys, and she had a habit of digging them into our heads. If we were talking at mealtimes, she would come up behind us and hit us with the keys. They are what I remember most about [SR 31]".[320]

HIA 195 also alleged that SR 31 hit them with keys.[321] SR 31 told the police that she only held one or two keys, and she suggested that the witnesses had colluded and shared information.[322] HIA 175 responded

317 SNB 1882.
318 SNB 873.
319 SNB 013.
320 SNB 794.
321 SNB 172.
322 Day 101, pp.54 to 55, 57 to 59, 64 to 66.

that no one had put being hit with keys into her head.[323] HIA 29 said that SR 31 carried her cane all the time, but sometimes she used a black leather strap. HIA 9 said SR 31 also used a mop handle to hit her across the legs.[324] According to HIA 39, SR 31 also took girls' pants down to smack them on their bare bottoms.[325]

180 Girls were hit for a variety of reasons. HIA 124 said that if girls back-chatted or tutted or showed an expression the nuns did not like they were taken to SR 31's room to be caned, to beat the stubborn streak out of them.[326] HIA 84 said that when she cut her knee, SR 31 had no sympathy and beat her for being out of bounds, leaving the cut on her knee to become a permanent scar.[327] HIA 195 said that SR 31 beat her in school for being left-handed. When HIA 84 was caught wearing pants in bed, SR 31 stripped her of her pants and beat her on her bare bottom in front of the whole room.[328] HIA 124 said that SR 31 checked girls' beds at night to see if they were wet, and slapped her about the heads and legs when she wet the bed, making her kneel outside SR 31's cell "all night", praying to God not to wet the bed again.[329]

181 The result of SR 31's regime of punishments was that some girls were cowed. HIA 39 was very wary of SR 31 and she was always on her guard, as she saw her hit another girl very badly with a stick.[330] HIA 195 felt she:

> "could never do anything right. I was sure to get a slap every day. [SR 31] had her favourites, but I was her punch bag".[331]

HIA 124 wrote:

> "I was terrified of [SR 31]. No matter what you said or did you got hit so it got to the point where I was so subdued I never said anything."[332]

182 Some girls responded defiantly. HIA 197 told us that on one occasion when she was beaten she refused to cry, so SR 31 kept on hitting her, and she had to be kept off school for a week because her hands were black

323 Day 100, pp.132 to 133.
324 SNB 003.
325 SNB 802.
326 SNB 694-695.
327 SNB 722.
328 SNB 722-723.
329 SNB 836.
330 SNB 246.
331 SNB 171.
332 SNB 838.

and blue and swollen.[333] HIA 430 said that she was sent to a store room just outside the dormitory for punishment but as HIA 430 was stubborn and did not cry, SR 31 did not like it and hit her more.[334] She told us:

> "...the more I didn't cry, the more she hit me, just because I think I was just stubborn and wouldn't give in to her..."[335]

183 HIA 37 said that when she and another girl truanted, SR 31 locked her in a room to prevent escape and beat her severely. HIA 37 claimed that she fought back, trapped SR 31 in a corner and made her surrender the key, so that she could get out. HIA 37 said she reached her uncle's house, who took her to the police and arranged for a medical examination. Neither the police nor the doctor could believe that a nun would inflict such injuries, and HIA 37 was returned to Nazareth House. She understood that SR 31 was disciplined.[336]

184 HIA 124 said that on the only occasion when she stuck up for her disabled younger sister, SR 31 put her in a drying cupboard on the second floor, where there was just enough room between the racks for a child to stand in the total darkness; she was left there for some time, and when she came out she had missed dinner and SR 31 put her back in the cabinet for answering back.[337] HIA 84 said that SR 31 locked her in a brush cupboard for telling lies, when she reported that an elderly resident in the home had molested her.[338]

185 HIA 430 told us that some children escaped punishment. HIA 195 contrasted the treatment of SR 31's favourites with her role as SR 31's "punchbag".[339]

186 Witnesses complained of SR 31's cruelty in dealing with children with psoriasis. HIA 195 said that when she had psoriasis, SR 31 cut off her hair, shaved her head and scrubbed her scalp with a scrubbing brush till it bled. When she screamed, SR 31 hit the top of her head with the brush, and the more she screamed, the more she was battered.[340] HIA 195's social worker noted that HIA 195 was "easy and co-operative"

333 SNB 694-695.
334 SNB 802.
335 Day 109, p.30.
336 SNB 063-065.
337 SNB 838.
338 SNB 722.
339 SNB 171.
340 SNB 174.

and had "taken the whole thing the treatment extremely well".[341] HIA 28 said that when three new girls were admitted with sore heads, SR 31 made her scrub their heads till they bled; she cried and so SR 31 hit her over the head with keys because she was not scrubbing hard enough.[342] HIA 161 alleged that SR 116 scrubbed her between the legs with a scrubbing brush, causing her pain.[343]

187 SR 31 was said not only to humiliate the girls but also to denigrate their parents, which the witnesses had found distressing. According to HIA 430, SR 31 would say:

> "You're illegitimate and you're a bastard. Who asked you to come here? We didn't ask you to come here. Your mother left you here".[344]

HIA 175 said that her mother visited every week and sometimes they went out. SR 31 ran her mother down, saying she was an alcoholic:

> "The way she spoke about mum has filled me with a hatred of her that has hurt me more than any of the physical abuse I suffered".[345]

188 SR 31 called the girls names. HIA 327 said:

> "Her comments hurt me more sometimes than being beaten. That's what stuck in my head more than the beatings. She was always humiliating us".[346]

When her mother visited, the nuns made fun of her and said she was living in sin. SR 31 read out a letter of complaint which HIA 327's mother had sent, pointing out the spelling mistakes. She said that when she was older and complained, SR 31 said:

> "You should never have been born. None of you should ever have been born. Your mother wasn't even married".[347]

189 With her combination of physical and emotional abuse, SR 31 stirred up considerable feelings of animosity among the witnesses. HIA 124 said that SR 31 was a very angry woman and "you would see her face going red with rage".[348] HIA 84 thought SR 31 very cruel and a bully. HIA 39 said:

341 SNB 46682.
342 SNB 048.
343 Day 98, p.59.
344 SNB 803.
345 SNB 163, 61464.
346 SNB 795.
347 SNB 795.
348 SNB 836.

> "[SR 31] should not have been a nun. She was very wicked and she showed no emotion or affection".[349]

HIA 29 also described SR 31 as wicked, while HIA 37 considered SR 31 "the most evil person" she had ever come across in her life.[350]

190 Having made allowance for exaggeration because of the strength of feelings which SR 31 engendered, we are clear that she physically and emotionally abused many of the children in her care.

SR 134

191 SR 134 was at Nazareth House from 1953 to 1970 and she was responsible for the Sacred Heart group.

192 According to the witnesses, the forms of physical abuse employed by SR 134 were varied. HIA 28 said that SR 134 used to beat her with a wooden walking stick like a shillelagh, and she hid it under her clothes if she saw anyone like the priest coming.[351] HIA 124 said she was hit over the head by SR 134 with a big bunch of keys. It was only later that day that she found out from another girl that SR 134 had not liked the noise made by the scrunching of leaves. HIA 124 commented that the nuns always hit them on the temples with their keys or their knuckles as the girls did not bruise there.[352] HIA 95 said that in the schoolroom SR 134 hit girls' knuckles with a ruler or used the cane, carrying on till the girl cried. HIA 161 said that SR 134 whacked girls on the knuckles with a big silver serving spoon, such that their hands became swollen and could not be moved.[353]

193 SR 134 was also said to abuse girls physically directly. HIA 52 said that:

> "[SR 134] used to dig into the soft flesh under your arms with her fingers. The nuns would hit you on the head as well either with their knuckles or these big sets of keys they carried round."[354]

According to HIA 20, SR 134 used to nip girls or pull their hair if she thought they were misbehaving in church.[355] HIA 103 said that when she was given a BCG injection by the doctor, SR 134 thumped her on the arm

349 SNB 244.
350 SNB 063-065.
351 SNB 043.
352 SNB 839.
353 SNB 665-666 and SNB 150.
354 SNB 811.
355 SNB 181.

and it became swollen and infected.[356] HIA 95 told us that she and one of her sisters were in SR 134's group:

> "You got thumped by her for anything - there didn't have to be a reason. ...She would grab you by the ears and pull you over to a door and bang your head off the door. She used to bang our heads off the wall outside as well".[357]

HIA 95 added that the grounds for punishment could be failure to do work properly, for example if a floor were not clean enough, or for no apparent reason; it depended on SR 134's mood.[358] When HIA 62 and a friend climbed over the wall and bought a lot of penny chews to share with the other girls, SR 134 caught them, and shaved their heads in front of the other children.[359] At school she had to wear a tea cosy as her head was cold.[360]

194 HIA 14 said that when she went up early for a bath, while the water was hot and clean, SR 134 shouted at her, grabbed her hair and repeatedly pushed her head under the water, holding it down and then pulling her back up by the hair. She remembered being petrified and unable to breathe. She was then beaten with the leather belt which SR 134 wore around her waist. HIA 14 said she had been left with a fear of water, and was unable to take her sons swimming as children and still did not enjoy taking baths.[361]

195 Three witnesses, HIA 20, HIA 95 and HIA 37, said that SR 134 grabbed girls' hands and made them batter themselves, saying "I'm not hitting you, you're hitting yourself" or "See, I didn't touch you."[362]

196 HIA 95 provided detailed evidence about the way in which SR 134 treated her. As a child HIA 95 suffered a nervous tic, and when she made involuntary movements in Mass SR 134 hit her, once so hard that she saw stars, or stuck a pin in her or "crunched" her in the back. When HIA 95 refused to eat porridge, SR 134 pushed her face in it. She threw brushes at girls when they were polishing their shoes on Saturdays. She shut HIA 95 in a cupboard. She gave girls hidings if there were marks when their underwear was checked.[363] The consequence, HIA 95 said, was that:

356 SNB 072-073.
357 SNB 661.
358 Day 97, pp. 29 to 31, 80.
359 SNB 675.
360 Day 99, pp.71 to 72.
361 SNB 117.
362 SNB 59, 181, 662, Day 107, p.145.
363 SNB 663.

> "I lived in constant fear in the home. If you weren't getting hurt yourself, you were watching somebody else being beaten".[364]

197 HIA 62 wrote:

> "When I was fourteen [SR 134] was sent away to Hammersmith and a young nun called [SR 153] took her place. [SR 153] was a breath of fresh air. She was twenty-four and she was really artistic. She started to paint flowers on the bare walls of the dormitories and she made a list of all our birthdays. We all got a cake on our birthday - that was the first time we ever had any recognition of our birthdays. [SR 153] had just come from South Africa and she was so compassionate and caring. She saved me. She gave me a purpose in life and was the closest thing to a mother I ever had."[365]

198 This evidence demonstrates the importance of the impact of different individuals on children in their care. We are persuaded by the evidence that SR 134 used a variety of forms of informal physical abuse in her dealings with the children in her group.

SR 116

199 SR 189 was replaced by SR 116 who was at Nazareth House from 1961 to 1967, running St Anne's group. She was seen as nice to begin with, while she was a novice, but HIA 37 said she was clearly influenced by the other nuns and became cruel like them.[366]

200 Several witnesses alleged physical abuse by SR 116. HIA 95 said that SR 116 took girls away upstairs and when they returned they had either been given sweets or they were crying.[367] HIA 37 said that SR 116 used bamboo canes - split and sellotaped together. HIA 20 said that SR 116 had a classroom and girls were made to stand outside and wait for her to call them in for a beating. She used a bamboo cane and hit her until she cried, so she learned to cry as quickly as possible.[368] HIA 316 said that SR 116 would always hit her on the knuckles where it hurt the most. She never got hit on the palm, and she used to have swollen black and blue knuckles all the time.[369]

364 SNB 662.
365 SNB 676.
366 SNB 058.
367 SNB 663.
368 SNB 183.
369 SNB 829.

201 HIA 61 thought SR 116 the worst nun as she kept picking on her:

> "…always beating me over the head and smacking me across the ear. Sometimes she just hit me with her hand and sometimes she used the metal crucifix of her Rosary Beads, her big leather belt or a big bunch of keys."

HIA 61 considered SR 116 "quite sly" as she only hit her when no one else was around.[370] On one occasion she woke up with a bandage on her head, having been hit by SR 116 on the side of her head such that her head hit a mirror. She had hearing difficulties subsequently.[371] HIA 61 was seen by a specialist who, she said, attributed her loss of hearings to the beatings she had had. She was sensitive about having to wear a hearing aid and tried to conceal it with her hair, but SR 116 embarrassed her by showing the other children.[372]

202 HIA 52 said that once SR 116 gave her a "bad beating" in a room beside the dining room:

> "She really lost her temper and lashed out at me. I was trying to protect my body so my back ended up black and blue from the hiding. It was extremely painful."

In consequence, when a teacher at school suggested that she should try on a dress she was making, HIA 52 declined, because the teacher would have seen the marks from the beating.[373]

203 When HIA 161 stayed with a family on a farm in Lurgan, the father and his brother both sexually abused her. HIA 161 told another girl, who informed SR 116, who gave HIA 161 the biggest beating of her life for "telling tales on a good Catholic family". SR 116 washed her mouth out with carbolic soap, and HIA 161 learned not to report abuse.[374]

204 HIA 257's view of SR 116 was more even-handed; although SR 116 used a roly-poly stick, a cane and a block of wood to hit her, she felt the punishments were justified and she was never hit gratuitously.[375]

205 HIA 29 said that SR 116 was the worst on bath night, as she used a scrubbing brush on their private parts. She found that the Jeyes fluid

370 SNB 769.
371 SNB 770.
372 SNB 771.
373 SNB 813.
374 SNB 151-152.
375 SNB 338-339.

burned her badly, and made her skin brown, but the girls were not allowed to wash it off.[376] HIA 14 said that when she wet her bed SR 116 called her a "filthy cow", grabbed her head and pushed her face into the wet sheet.[377]

206 HIA 63 summarised:

> "She should never have been in charge of children; she had no compassion whatsoever."[378]

Both HIA 96 and HIA 52 saw SR 116 as a wicked woman.[379] According to HIA 61, SR 116 had problems wherever she went and had to keep moving countries and changing her name; she was also said to have had mental health problems when she joined the Order at the age of 18.[380]

207 We accept from the evidence that SR 116 abused some of the children in her care both physically and emotionally.

208 In summary, there were nuns (and later lay staff) throughout the time that the witnesses were in Nazareth House who physically abused children in ways which were contrary to the Congregation's policy. In particular, four sisters were identified as being the subject of the greatest number of allegations, highlighting the importance of the individual workers and the impact they can have on the lives of children. The fact that they were able to continue to abuse children over a period of years also raises questions about their selection, supervision and management. Their practice may have reflected the way in which some parents and teachers chastised children at that time, but it was contrary to the statutory Regulations and unacceptable as professional residential childcare. **We are satisfied that several sisters and in particular SR 189, SR 31, SR 134 and SR 116 systematically abused children physically and that this was a systemic failing.**

Emotional Abuse

209 The emotional abuse associated with physical abuse has already been noted. This section contains further examples where emotional abuse was alleged. The instances which witnesses found emotionally hurtful were very varied.

376 SNB 011.
377 SNB 116.
378 SNB 686.
379 SNB 663, 811.
380 SNB 771.

210 HIA 387 said she was emotionally abused and humiliated:

> "The nuns constantly told us that no one wanted us because we were bad, we were orphans."[381]

When she had her first period:

> "The nuns told me I was an evil wicked child because of what the devil had done to me. They never told me what was actually happening to me."[382]

211 When HIA 439 ran away with three or four other girls, they were returned by the police and the nuns shaved their hair when they returned so that they could be identified and known as the runaways."[383] The Order does not accept that this happened.[384]

212 HIA 171 remarked that the nuns did not like her talking to or playing with her sisters. She said:

> "The nuns tried to divide everybody; even if you got close to a friend and were having a laugh they would try to divide you".[385]

This was echoed by HIA 223 who wrote that the nuns did not like to see the girls make friends and tried to split them up. As an example, she described SR 31's attempts to break up her friendship with NHB 52, which resulted in HIA 223 being slapped and beaten on three consecutive nights.[386]

213 HIA 52 said:

> "I didn't really make friends in the home because you could never get too close to someone. You were not allowed to have friendships. We never knew anything about comfort or love. If you saw another child crying, your instinct would be to go put your arm around them but if the nuns saw that, you would get a hiding. We were never shown any love. You were completely on your own. There were no social connections at all; it was just work, work, work."[387]

These examples may have reflected the expectation within the Order that special friendships should not be formed as they could undermine the

381 SNB 385.
382 SNB 387.
383 SNB 204.
384 SNB 2042.
385 SNB 781.
386 SNB 316.
387 SNB 810.

community ethos. Nonetheless HIA 166 concluded:

> "I formed strong relationships with some of the girls I grew up with and we are still in contact today. We only had each other as we were never shown any type of love or affection from those in charge of our care. I believe the nuns didn't know how to show love or affection."[388]

Some examples related to the way sisters dealt with the girls' families. SR 131 put HIA 171 in an isolation room after her grandmother had visited; she had hoped to go to stay with her, and SR 31 pointed out that if this had been possible she would not have been in Nazareth House. Grandmother stopped visiting but it was some time before HIA 171 learnt that she had died. She cried inconsolably, and was again placed in an isolation room as SR 31 thought she was waking everyone up with her "nonsense".[389]

214 HIA 161 said that SR 116:

> "…pulled me up by the hair and lifted me off the floor and she said 'Your mother is nothing but a prostitute anyway, a drunk and a prostitute, and that's how you're going to turn out'".[390]

HIA 161 said that this type of thing was said daily and she was never shown love or affection. She said she was called "scum of the earth"[391] and in oral evidence she said that the nuns declared that there was "no room in heaven" for her family, such that she thought the problem was her family name.[392]

215 HIA 197 said that the nuns told her she was ugly, dirty and worthless. When people visited to invite children out, she was sent to the back of the queue. She said she was never given any praise or encouragement and was told by the Mother Superior that she would be damned to hell.[393] HIA 134 said that "[SR 31] was very cold and I felt much neglected in the home".[394] HIA 134 said that SR 31 struck her name off the lists for parties, and she was given a toothbrush for Christmas.[395]

216 HIA 43 said that the memory had stuck with her of the occasion when she was humiliated and laughed at in front of the other children for having

388 SNB 293.
389 SNB 781.
390 SNB 146.
391 SNB 145.
392 Day 98, p.34.
393 SNB 695-696.
394 SNB 866.
395 SNB 867.

soiled pants. She had tried to conceal them, but her number made them identifiable. She felt that SR 31 despised her:

> "She was constantly putting me down, degrading me and making me feel stupid and worthless".[396]

She said that the nuns had favourites, who were given sweets, cinema trips and weekends with families, but HIA 43 was not given these opportunities. She concluded:

> "Those nuns should never have been involved in the care of children. They seemed to hate children; you could see it in their eyes".[397]

217 HIA 20 found teasing by other children hurtful when she was called 'fish' for bedwetting and 'dunce'. However, she found the nuns' cruelty worse, and she said they were constantly degrading the children. SR 31, for example, said:

> "Nobody wants you. Do you know why you are here? You were just dumped. Nobody wants you".

In consequence, she felt that she was only fit to scrub floors, work in the laundry and wash up in the kitchen.[398]

218 Several witnesses said that they were threatened with removal, for example to Muckamore Abbey, a special needs hospital, Middletown, a training school, or Good Shepherd, which operated a laundry where adults and a few older girls worked. HIA 63 said that these threats terrified the girls as they did not want to be separated from their siblings, and they had heard that girls who went to Middletown were never seen again.[399]

219 HIA 250 was at Nazareth House throughout her childhood from 1955 to 1972. She took a balanced retrospective view of the emotional care she received:

> "Our life in the convent was basic, which you would expect. We were fed and given a roof over our heads. Our basic needs were met, but there was no emotional side to it; there couldn't be. Who were we to get that off? In my view that was just a product of society in the fifties - who did care? My family did not. It was worse on the outside than it was on the inside. ...I was an orphan, totally on my own".[400]

396 SNB 715.
397 SNB 715.
398 SNB 186.
399 SNB 687.
400 SNB 819-820.

220 It will be noted that some of the above examples related to the four nuns who were the main abusers. When SR 31, SR 134 and SR 116 ran the three groups there would have been no one to whom the girls could turn for comforting, and the whole atmosphere in the home would have been emotionally abusive, though it is possible that any favourites may have received care and attention.

221 The examples above indicate that some of the sisters belittled or humiliated some of the girls, by denigrating their families, telling them that they were evil rather than encouraging them to build up their self-confidence, breaking up friendships, failing to support girls when they were upset, and threatening them with removal to an institution deemed more punitive. **We conclude that the emotional abuse suffered by some girls was systemic.**

Sexual Abuse by Staff

222 There were only five possible allegations of sexual abuse by staff.

223 HIA 298 said that in the late 1940s a lay worker was bathing her at 4am, and she inserted her fingers into HIA 298's vagina. She recalled the horror of the experience, but being about nine years old there was nothing she could do about it.[401]

224 HIA 387 said that in the 1950s two nuns used to take her and other girls to the bathroom at night. Having taken off her nightdress HIA 387 had to stand on a table and spread her legs so that they could examine her, with one of the nuns putting her finger in HIA 387's vagina. The nuns also hit her, laughed at her and called her smelly and dirty.[402]

225 HIA 387 also alleged that a priest raped her in the sacristy after she had made confession. Her written and oral accounts are convincing. She told a nun some years later and was promptly transferred to the Good Shepherd Convent.[403]

226 HIA 117 said that in the late 1960s when she was about eight or nine years old a lay worker tried to get into her bed but she beat her out of it.[404]

227 HIA 316 recollected that when she was seven or eight she awoke one night to find a priest standing by her bed and her nightdress was around

401 SNB 702.
402 SNB 388.
403 SNB 389,390.
404 SNB 875.

her waist, but she had no memory of anything sexual happening. When she awoke he moved away.[405] The Order said that a priest would ordinarily have been accompanied by a nun, and NHB 84, who was the chaplain at the time, said he never visited the children at night.[406] We accepted NHB 84's evidence though we cannot provide an explanation of HIA 316's experience. While there was no explanation for HIA 316's experience we accept that it was a vivid memory for her.

228 The incidents described in the evidence are all different and they do not form an overall pattern to suggest that sexual abuse was commonplace at Nazareth House. This is not to deny the seriousness of the allegations made by the witnesses, but to conclude that they should each be treated as individual instances.

Fr Brendan Smyth

229 Fr Brendan Smyth was a member of the Norbertine Order. He travelled widely in Northern Ireland, visiting children's homes and abusing large numbers of children. The Order acknowledged that he visited Nazareth House, and a number of witnesses made allegations that he had sexually abused them. He was eventually arrested and he died in prison. Chapter 10 deals more fully with his history.

Physical Abuse by Girls

230 There were few references in the evidence to physical bullying by peers. HIA 161 said that she was picked on by other girls, for example being tossed in a sheet, but that the nuns never intervened.[407] The nuns had favourites, known as their pets, who were given fruit and taken to parties, and when they bullied other girls the nuns turned a blind eye.[408] Some bullying in a large home like Nazareth House could have been expected, and we do not consider from the evidence that this amounted to systemic abuse.

Sexual Abuse by Girls

231 HIA 28 alleged that when she was eleven or twelve an older girl made her take off her nightdress and get into her bed, lying on top of HIA 28, kissing her, touching her breasts and vagina, and making her reciprocate. This

405 SNB 829.
406 SNB 2143,80077.
407 SNB 149.
408 SNB 148.

continued about twice a week for four to six months, when the older girl took to somebody new.[409] HIA 85 was sexually abused a number of times by older girls who forced her to perform oral sex on them; these were her most traumatic experiences in the home.[410] HIA 103 said that an older girl tried to get other girls to touch her, but she always pulled her hand away.[411] The older girl said that HIA 103's statement was untrue.[412]

232 When she was eight or nine, HIA 134 told another girl in secret that an older girl was sexually abusing her, but the message was passed on and reached SR 199, who was responsible for HIA 134's group. She called HIA 134 a liar, which humiliated and devastated her.[413]

233 HIA 134 said that she and one of the two boys then in the home attempted sexual intercourse, but it hurt her and she pushed him off.[414] It seems that this was experimental and that they were of a similar age. HIA 368 was admitted to Nazareth House at the age of eight, and he said that older girls in their mid-teens abused him sexually by making him "climb up their nightdress and touch them intimately".[415]

234 The six instances described above appear to indicate exploration by adolescents. In view of the number of girls who passed through Nazareth House, the scale of sexual activity is unsurprising, and it is likely that the staff were in most cases unaware of it.

Inspections

235 The information available about the formal inspection of Nazareth House is very limited, and it was suggested by Dr Hilary Harrison that when the home was closed records would have been destroyed in accordance with Departmental schedules for the disposal of records.[416] It was the practice of the Ministry of Home Affairs to make annual visits, though there was no requirement as there was for industrial schools (which Nazareth Lodge was pre-1950). There are references to annual visits by MoHA inspectors in the home's log for 1953, 1964, two in 1965 and 1966,[417] but while

409 SNB 047-048.
410 SNB 268.
411 SNB 072.
412 SNB 80094.
413 SNB 866.
414 SNB 868-869.
415 SNB 656.
416 SNB 9550.
417 SNB 10308, 10327, 10334, 10335, 10344.

the visits were termed 'annual', there were clearly gaps when visits were not made or when they were not recorded. Since the logs list all the films shown in the home, Christmas parties and trips out, the annual visits cannot have registered as a high priority when the log was written up. Some of the one-line records indicate that the inspectors were happy with the quality of care.

236 Speaking of the 1960s, HIA 171 said:

> "When visitors came to the home we were told the night before that people would be here and that we should all be nice. I am not sure if they were visitors or inspectors or what they were called. We were told to be up and on our best behaviour before any such visit. The nuns were the ones who were on their best behaviour on these occasions. When these visits took place you would see things coming out that we have never seen, such as books and dolls. We were never allowed to play with these toys. If any visitor had inspected any of the toys they would have noticed that they had not been played with and that the children just looked at them as if they were something out of space."[418]

237 It is reasonable to assume that the pattern of later inspections followed that which we have found in other homes. In 1973 the Social Work Advisory Group was set up, and in accordance with its name it ceased to inspect and offered support and advice instead. Following the Hughes Report it was decided to inspect all homes, and between 1984 and 1986 a systematic approach was taken by the Department of Health and Social Services to inspect all homes. This did not affect Nazareth House, however, as it closed in 1984. There is no record of the SWAG inspecting Nazareth House although there were references in the evidence given to the Hughes Inquiry of a Social Work Adviser visiting the home. **We consider this lack of inspection amounted to a systemic failing by SWAG to ensure that the home was meeting statutory regulations and providing proper care.**

238 There is also very little evidence of complaints in the records which have survived concerning Nazareth House. In the minutes of a divisional group meeting of the Belfast Welfare Authority on 14 June 1971, dissatisfaction with Nazareth House's procedures was voiced; cases had been documented and forwarded to Mr Moore, the Chief Welfare Officer, but at that point no action had been taken. There is no further reference to this concern.[419]

418 SNB 782.
419 SNB 18975.

Conclusions

239 The majority of the allegations about abuse at Nazareth Lodge relate to the 1960s and 1970s when the four sisters whose conduct has been considered individually were in post. Witnesses who were resident during that period look back on their time in the home as bleak misery.

240 HIA 197 felt that:

> "The whole environment of the home and the school was fear. ...The punishment seemed unnecessary for some things. It was just a way of frightening us and keeping us down".[420]

With hindsight HIA 375 said of Nazareth House in the 1960s:

> "The nuns did not have any childcare skills or understanding of children. They did not know how to show us love or comfort us. I found out in later years that they were being paid to care for us. I am still angry with Social Services as it was their duty to make sure our physical, emotional and educational needs were being met by the Sisters of Nazareth but they didn't do this".[421]

241 HIA 37 said:

> "Nazareth House was a bleak, dark place. I suffered physical and mental abuse on a daily basis during the nine years I was kept there. This amounted to thousands of incidents. I remember I used to just lie in bed and think this is a nightmare".[422]

HIA 9 concluded:

> "I have no good memories of my time in Nazareth House, only bad ones".[423]

242 It should be noted that once the four nuns had left the home, the flood of allegations virtually dried up. The many witnesses quoted by the Congregation in their final statement who enjoyed aspects of their time at Nazareth House or Nazareth Lodge may have been as truthful and accurate in their accounts as those who made allegations. The fact that some children were not abused does not mean that those who complained did not suffer abuse.

420 SNB 694.
421 SNB 732.
422 SNB 054.
423 SNB 002.

243 The allegations of physical and emotional abuse have to be seen against a background which Nazareth House, Belfast, shared with other homes run by the Order. Resources were very limited and it was said that they were chasing the devil by the tail to get more money.[424] Yet they did not want to turn any girl away. The outcome was that the number of staff was insufficient to provide individual care, and some of the physical conditions were also poor. A further consequence was that standards of care were not up to date and the girls suffered institutional practices which should have been superseded.

244 It is noticeable that standards improved from about the mid-1970s onwards, and by the time the home closed it was offering good standards of care.

Summary of Findings

245 The following are our findings:

(a) Many of the tasks which the girls were required to perform were of little use to them as preparation for managing their own households, and in our view the excessive chores expected of the girls constituted systemic abuse.

(b) The infrequency of changing bath water, the use of carbolic soap to clean teeth, the use of Jeyes fluid in the bath, the rough treatment when bathing and the queuing were outdated institutional practices which should have been superseded or never adopted in the first place, and they constituted systemic abuse.

(c) The punitive approaches described in the evidence would not have given the children any sense of security but would have added to their anxiety; the measures would have been ineffective in dealing with enuresis and constituted very poor childcare practice, amounting to systemic abuse.

(d) The home nursing described was very poor in terms of the failure to take some problems seriously, the rudimentary treatment given, the physical abuse on some occasions, and the lack of loving care for children who were unwell. This amounted to systemic abuse.

424 SNB 50752.

(e) **There was no valid childcare justification for confiscating the children's personal possessions, and this constituted systemic abuse.**

(f) **During the earlier decades, the combination of aspects of poor childcare (such as excessive chores, an institutional approach to bathing, the use of Jeyes fluid, the handling of menstruation and sex education, the poor quality of food, the insistence on eating unwanted food, the failure to celebrate birthdays, the poor quality of education at the school on the premises and the failure to prepare children for discharge) which were all below the standard which might reasonably have been expected at that time we consider amounted to systemic abuse.**

(g) **The public corporal punishments inflicted in the 1950s constituted systemic abuse.**

(h) **The range and variety of examples and the number of witnesses, particularly in relation to SR 189, SR 31, SR 134 and SR 116, indicate that the physical abuse practised by the staff was systemic.**

(i) **We conclude that the emotional abuse suffered by some girls was systemic.**

(j) **We consider the lack of inspection amounted to a systemic failing by SWAG to ensure that the home was meeting statutory regulations and providing proper care.**

Chapter 9:

Module 4 – Sisters of Nazareth, Belfast: Nazareth Lodge

Site and Premises

1 Nazareth Lodge faced on to Ravenhill Road in the south side of Belfast. It had extensive grounds, including a small farm, a walled kitchen garden and playing fields for the children, together with a range of outbuildings used as garages and stores. The main building was imposing. It was approached up a curving drive and consisted of four storeys, with a small tower at the corner.

2 In a written submission, HIA 159 gave a graphic description of the farm:

> "Nazareth Lodge had its own farm, which though not self-sufficient was able to contribute a great deal towards the running costs…".[1] "The farm took in a large rectangular area, which had hens, ducks, pigs and cows. Three or four men ran the farm."

They looked after the animals, the boiler, the hedges, and the graveyard.

> "We were allowed to watch the cows getting milked and pigs but not the hens, just in case we frightened them and they stopped laying, but we could go almost anywhere else".[2] "For a number of months each year sheep were allowed to graze the big field with its swings and sandpit where we played every day".

The boys were let off school to help get the sheep onto a lorry, but they ran all over the place. "The fun was great, the laughter merry".[3] HIA 87 said that a walled kitchen garden ran the length of the building, where they grew cabbages and turnips.[4]

3 According to HIA 159 a large area was concreted over in front of the main house, where they played football, rounders and gymnastics. There was also a large field with swings, sand pits and a large climbing frame. In the summer a fair left a large merry-go-round at the bottom of the field near the main road. They played tig, hide and seek, marbles, hop-scotch and with hoops. They also had tricycles and scooters.[5]

4 HIA 159 said that after 1953-54 a baby home and a caretaker's cottage were built halfway up the drive. The people who worked for the home, such as gardeners and cleaners and some tramps seeking assistance, went to

1 SNB 32183.
2 SNB 32183.
3 SNB 32184.
4 Day 83, p.58.
5 SNB 32187.

the side of the main house for tea, bread and dinner.[6] This meant that there was some risk that such visitors could have access to the grounds where the children were playing.

5 The main block was a red-brick four-story building.[7] On the bottom floor of the main building there was an entrance hall where visitors were met, and to the right there was a bedroom for visiting priests, which was used from time to time by Fr Brendan Smyth. Also on the ground floor there was an assembly hall which was used as an indoor play room. HIA 159 said that the hall was also used for plays at Easter and in the New Year, which provided an opportunity for visitors to meet the boys, and that this sometimes led to visits on Sundays or weekends, and maybe eventually to adoptions. Later the hall was used for storage, including parcels from parents which, it was alleged, were not given to the boys, who did not know about them until years later.[8]

6 HIA 159 said that the main house had its own laundry, a washroom and a boiler room which supplied all the hot water and heating. The clothes were dried on great hot pipes.[9]

7 The main house had a connecting corridor to the nursery, and halfway along the corridor a door on either side led to the front door of the home or to the yard at the back, where there was a grotto to Our Lady. The kitchen was at the end of a corridor. On the right was the dining room and on the left another small corridor leading to the hall, the back yard and the farm.[10]

8 Until a purpose-built school was opened, there were three classrooms in the main house. In HIA 159's time:

> "[SR 34] had the first class room at the beginning of the corridor, Mr Fern the second, and Miss Comfort the third, and [there was] a smaller room for boys a bit slower taken by another nun. After 1954-5 a dozen boys who could not pick up schooling very quickly were sent outside to a special school for slow learners".[11]

6 SNB 32185.
7 SNB 50497.
8 SNB 32184.
9 SNB 32187.
10 SNB 32190.
11 SNB 32190.

HIA 24 said that in the 1940s the school room in the main house was used to show films.[12] HIA 159 said they had religious films, comedies and cowboys and indians. The hall was also used for plays at Easter.[13] The partitions which separated the classrooms were pushed apart and two sets of chairs were set out on each side of the classroom, with a centre aisle separating the boys and girls.[14]

9 On the first floor there was the chapel. The nuns also had their living quarters there, and the community included not only the sisters who cared for or taught the children, but also those responsible for 'questing' – obtaining funds through the house to house collections. There were also often some older nuns who continued to live in retirement as community members. Other than the sisters who had cubicles in the children's dormitories, all the sisters slept and lived in the nuns' quarters, and the whole group ate there. The children had no access to the sisters' accommodation.

10 The two upper floors of the main block were used as living quarters by the children. Originally there were two large dormitories, each taking up a whole floor, but these were divided into two about 1950, so that there were four dormitories, each housing about 30 boys, grouped by age, but with older boys in each one to keep order. There were at this time five groups in all, one being the Bethlehem group for babies and toddlers. According to HIA 89, bedding and heating were satisfactory.

11 With the opening of St Joseph's Babies Home, the Bethlehem group was closed and it was converted into accommodation for older boys. The number of groups was reduced to four, and then three, in the early 1960s, and this was the format during the period which was subject to most of the allegations of abuse.

12 An important development was the refurbishment of the accommodation for the groups about 1975, with the introduction of a mixture of bedrooms for three children and single bedrooms for older children on the third floor,

> "to give them privacy, personal space, independence and enable them to study and do homework in peace."[15]

All rooms and corridors were carpeted and had dressing tables and wardrobes. According to NL 4 it was in SR 172's time that the bedrooms

12 Day 83, p.69.
13 SNB 32184.
14 SNB 32185.
15 SNB 1591.

were fitted with carpets, instead of tiles, doing away with polishing as a result, and each group had a verandah.[16] At the same time, bathrooms, playrooms with snooker tables, study rooms, dining rooms, kitchens and sitting rooms were introduced onto the upper floors, so that the group premises were self-contained, according to SR 46.[17] This was the first of the major changes which resulted in the updating and improvement of childcare standards in Nazareth Lodge, and fewer allegations relate to the subsequent two decades.

13 At this time each unit was headed up by a nun, assisted by one full-time and two part-time lay workers.[18] DL 40 was at Nazareth Lodge in the later 1960s and early 1970s, and he described the lay staff as very young untrained girls from the country.[19] He considered it "a big ask" for one nun and two teenage girls to have to care for twenty vulnerable children.[20] As demand for residential care diminished, the number of groups was reduced to three.

14 At the very top of the building there were attics, and these were used as dormitories at one stage during the Second World War, though this practice ceased after Belfast was subjected to the blitz. HIA 99 recalled that he saw air raids from an attic window, but the boys were moved and had to sleep in the basement in case of bombing.[21]

15 Because of the siting of the rooms within the building there was no need for children to go outside. This was not only convenient for the children, but it made supervision simpler for the nuns. The children were allowed outside in the grounds to play after school and at the weekends, but even then certain areas such as the garages were out of bounds. There were also times when the boys were taken out for supervised walks to the parks or to parties at Christmas. Over time, rules were eased and children were able to go unaccompanied to local shops, for example, but for many witnesses for the greater part of their childhood the children's world was bounded by the walls of the home.

16 Day 95, p. 79, and Day 113, p. 39.
17 Day 93, p.33, SNB 1586.
18 Day 93, pp.113 to 114.
19 Day 95, p.59.
20 SNB 1876.
21 Day 82, p.83.

The Groups

16 The group structure was set up under SR 34 about 1954.[22] There were five groups initially, including Bethlehem for the little children. Following the closure of Bethlehem, there were four groups, two on each floor, though there was a short period when NL 5 had a small group in the attic who became known as the 'Dainties' or 'Whippets'. The dormitories of the four groups were sited in two pairs, and there were adjoining doors, enabling staff, and sometimes children, to visit the other group on their level. The groups also had designated areas in the dining room. In the later years, as the overall number of children diminished, the groups were reduced in size from 30 to sixteen per group. Towards the end there were three groups, known by the names of the sisters in charge, reducing to two, then one just before closure.

17 These groups had considerable autonomy, depending upon the style of management of the Mother Superior. One Mother was known for visiting the units and talking to the children, for example, while another tended to see the management of the administration and finance as her role and stayed in her office, leaving the care of the children much more to the group staff. The four sisters responsible for the groups used to meet informally to discuss the running of the home and any problems arising at the time. The meetings were not minuted, and there were no general staff meetings.

18 Until the 1950s there was just the one sister per group, with no other care staff in support, though there were other sisters and ancillary staff working in the grounds, the kitchen, the laundry, and the workroom, where clothes were made and mended. The demands made by the care of thirty boys must have been considerable for the sisters running the groups. HIA 408, who was at Nazareth Lodge in the 1930s, said that the nuns were seen as angels, not humans, and that the boys were not allowed to talk to them, let alone feel able to tell them about abuse.[23]

19 In later years, civilian staff were appointed, first with one per unit, then two, and finally three. These staff were said to be mainly young girls, aged sixteen to eighteen, from the country, and until the later years no training was provided. The turnover of these staff was said to be high. Coping with boys who were not a lot younger than themselves must have been

22 Day 84, p.48.
23 Day 82, pp. 32 and 35.

demanding for such staff, and when the sisters were not present, at times they developed methods of control which represented poor childcare practice and in some cases abuse. Girls appear to have been admitted from the late 1960s, and by the mid-1970s there were five family groups, comprising 41 boys and 28 girls or 69 children in total.[24]

20 Each group was the responsibility of a nun, who had a cubicle in the corner of the dormitory with a curtained window from which she could observe the boys. HIA 204, however, reported that:

> "I was in St Joseph's, [then the junior] dormitory and [SR 118] was in charge. She had a cell at the end of the dormitory but it was the older boys who were in charge of us at night time."[25]

According to HIA 408 there were three rows of beds in the dormitory in the 1930s, all with rubber sheets in case of enuresis. HIA 99 said that the dormitory was warm and "scrupulously clean", with beds lined up in neat rows.[26]

21 The groups were:

(a) St Joseph's Group

(b) NL 5's Group

(c) Marion's Group

(d) Sacred Heart Group

(e) Our Lady's Group

Each of the groups was allocated a colour for their crockery in the canteen.[27]

22 One of the aims of introducing girls to Nazareth Lodge was to enable families to stay together. However, when HIA 141 was admitted in 1981, four of her siblings were placed in SR 46's group and three in SR 62's, but she was on her own in SR 29's group. Her siblings visited her and looked through the glass panels of the fire doors, but she had spent four years in St Joseph's Baby Home and did not know who they were.[28]

24 SNB 1592.
25 SNB 305.
26 Day 82, p.81.
27 SNB 211.
28 SNB 109.

23 The importance of the groups should not be underestimated. Although the children met residents from other groups at school and when playing outside, their main peer group consisted of the other children in their own group. In some cases they will have lived together for over a decade, and the groups developed some of the characteristics of a family, leading to life-long brotherly relationships.

24 Similarly, although the children met staff from other groups, for example in the dining room, it was the sister and lay staff in their own group who made all the difference to their happiness or misery. Indeed, witnesses said that if they were caught misbehaving by a member of staff who was not from their group, they were referred to the sister in charge of their group for punishment.

Admission

25 Many of the witnesses were admitted to the care of the Sisters of Nazareth as babies or toddlers. They were placed in the Bethlehem nursery section in the main building in the earlier years according to HIA 204 or in a separate unit later on, following the building of St Joseph's Baby Home, such as HIA 427. In these cases the admission to Nazareth Lodge would have been authorised by the Sister in charge of St Joseph's.

26 By the time the boys were moved from the nursery unit to one of the other groups in Nazareth Lodge they were used to institutional living. Other children were admitted direct to Nazareth Lodge. A few returned to their families, and others were fostered with a view to adoption, but the remainder stayed in the care of the Sisters in the earlier years. From 1953 they were in the care of the sisters till they were about eleven years of age and then transferred to the care of the De La Salle Brothers at Rubane. In either case, these children spent their whole childhood in institutional care.

27 HIA 33 was 12 years old on admission. He told us that his good clothes were removed and were not seen again. He said he was put in SR 118's group:

> "When she met us she asked me why I was crying and I said my mother had just died. She gave me a slap round the head and told me not to mention her again."[29]

29 SNB 138.

On his arrival, as the home was overcrowded, the boys were placed two to a bed in the attic. SR 118's group therefore filled the attic and the floor below. After a few months boys went to Rubane and to Australia, and the whole group was brought together on the floor below.

Daily Life

Routine

28 Witnesses varied in the details of their descriptions of daily routines, and indeed, practice may well have changed over the decades covered by the evidence. In general, former child residents thought that they got up earlier than the staff said they did, but it was pointed out that there were no clocks, so that we are considering people's impressions. HIA 87 said that in the late 1940s:

> "We were woken every morning at 6 am and had to attend mass at 7 am before we got our breakfast. Breakfast was usually porridge and a slice of toast."[30]

According to SR 30 and SR 46 the boys were awoken at 7.30am and had their breakfast at 8am.

29 Lessons in school took place from 9am until 3pm. The school was open for children from the community to attend, and applicants told us that the 'home children' were expected to sit at the back. In the later years, according to SR 46, children were enabled to continue to attend their schools by taxi where they were already registered.[31] During the week the children had school dinners.

30 According to HIA 87:

> "After school we had various chores to do around the home, like washing the floors, polishing the corridors, and cleaning the refectory".[32]

The children were then allowed out to play until tea-time. After tea, they were mostly allowed out to play again, but when they were called in from playing outside, they then began the evening routine of preparing for bedtime. It was one of the complaints of NL 5's group that she always called them in first, and that after going to bed at 6 pm, even in summer, they could hear the others still playing outside. After playing, there was

30 SNB 255.
31 Day 93, p.38.
32 SNB 255.

supper: HIA 87 said supper was usually at 6pm and consisted of bread and lard with a cocoa drink.[33]

31 In the evening the sisters had an evening meal and worshipped as a community. In later years, the lay staff took over supervision at this point. In the earlier years (in particular prior to 1953 when boys aged eleven were first transferred to Kircubbin) older boys were left in charge. HIA 159 said:

> "The older boys were in charge of us, especially when the nuns were in chapel at Vespers. Winter times were the worst as they took great delight in scaring us with ghost stories, making us run down the corridor from one end to the other, shouting, 'There's a ghost coming up', so we would run to the other end. We now know that it was somebody with a sheet over him and a Halloween mask on".[34]

32 More seriously, many of the allegations of abuse relate to this evening period. At different times both lay staff and older boys were reported to have abused the younger boys in the absence of the nuns. According to HIA 204, the nuns did not enter the bathroom at bathtime. Older boys aged 14 or 15 were in charge and sexually abused the younger ones in the toilet cubicles; he said he was "made to perform impure acts".[35] The senior boys had "full control" while the nuns were dining or praying in church,[36] but the sisters were in charge during the night.[37]

33 In the earlier years, according to HIA 159:

> "All the younger boys were in one long dormitory in two long rows with a fire place at each end which was sometimes lit to warm the dormitory before we went to bed. Later, each had a pillow every night. We only had them in the winter time in 1950s."[38]

HIA 408 said:

> "In bed you had to fold your arms across your chest",[39]

and HIA 5 added that SR 45 said this was "to get us ready for God".[40]

33 SNB 255.
34 SNB 32186.
35 SNB 305.
36 Day 82, p.8.
37 Day 82, pp.6 to 7.
38 SNB 32185.
39 SNB 219.
40 SNB 035.

34 HIA 408 said that two or three older boys were left in charge at night, and they hit him with brushes for not replying when they called his name or for not being asleep if he responded.[41] According to SNB 139 and HIA 33, if anyone made a noise at night they were made to kneel in the corridor with their hands above their heads by the class boys, and they were hit by the nuns and the class boys if they dropped their hands. HIA 408 said:

> "[SR 118] never came back to check on us during the night."[42]

HIA 307, however, said that nuns did come into dormitories at night to check that boys were settled and to deal with crying children.[43] He said he cried himself to sleep, that the beds were never warm enough, and that he "never [had] any sense of comfort or security".[44]

Chores

35 Chores were undertaken before or after breakfast on weekdays, and on Saturday mornings. Relating to the 1950s, HIA 33 said:

> "Every morning before breakfast, we had to polish the long corridors on our hands and knees. We used to do it in lines of five. Five would put the polish on, five would rub the polish in, five would give the first shine, and five would give the final polish. The class boys would supervise and if you stopped for any reason they would hit you. The class boys were other residents who were put in charge. They had sticks and were free to hit you anytime. If they did not hit us when the nuns thought they should have they were punished by the nuns for not showing their authority".[45]

36 It was perhaps in later years that it was after breakfast that the children each had chores to perform. Opinions about chores differed. HIA 99 said that floor polishing was enjoyable:

> "We all had to swing together in a row, back and forward with the polishing cloth while a nun stood over us".[46]

DL 40 said:

> "We all mucked in with helping to keep the accommodation clean. I used to love waxing and buffering the floors. We used the buffer as a ride for sitting on".[47]

41 SNB 219.
42 SNB 219.
43 Day 84, p.5.
44 SNB 097.
45 SNB 138.
46 SNB 279.
47 SNB 1875.

37 HIA 89, on the other hand, said that his main cleaning job was a large corridor, with three other boys. He did not enjoy the chores, "Never; never".[48] HIA 33 described the process, which was overseen by class boys, who slapped any boys who they thought were slowing up.[49] HIA 225 also complained of excessive chores, and said he was beaten if the work was not up to standard.[50] NL 5 saw the Saturday morning chores as something to occupy the boys while the sisters were out collecting.[51]

38 HIA 159 said that once a month the boys had their sheets and pillowslips changed and they turned their mattresses. They then gave the bedrooms a thorough cleaning.[52]

39 In 1944 an inspection report noted that the chores expected of the boys were appropriate.[53] However, during the period relating to most of the witnesses the system of chores at Nazareth Lodge was by this time well out of date. In many children's homes domestic staff would have been appointed to keep the communal areas clean; children would have been expected to look after their own sleeping quarters and to help out with other tasks such as preparing meals, with a view to their learning the household skills they would need when living independently. It is doubtful whether the Sisters could have afforded to appoint domestic staff. The systems they adopted kept the home clean and occupied the boys, but they bore no relation to preparation for independence.

40 We only received evidence of one instance which could have been considered seriously exploitative. HIA 422 reported that when he was nine or ten he was put through a hatch into the chimney at school and was given a wire brush to clean the inside of the boiler chimney. He was given no mask or protective clothing.[54] HIA 422 maintained his account in oral evidence. This type of task was clearly inappropriate for a young boy and was abusive, but as the only example it cannot be considered systemic.

Bathing

41 The institutional bathing routine figured frequently in the evidence. In the 1940s, according to HIA 87:

48 Day 83, p.7.
49 SNB 1641.
50 Day 87, p.28.
51 Day 114, p.67.
52 SNB 32193.
53 SNB 100208.
54 SNB 212, Day 85, p.56.

> "We usually had our baths on a Saturday evening at around 5 or 6 pm. There were three baths for the whole Lodge, and we were made to line up in two lines waiting for our turn. If you were lucky you were one of the first in the bath when the water was clean. We were stripped off and put into the bath in pairs, and were given an old sheet to dry ourselves with. If you were one of the last boys to get your bath, you were left with dirty water and a wet sheet to dry with. We had no privacy at bath times, as we were always being watched by the nuns. We did not have our own toothbrush, but had to share with each other. Modesty went out the window".[55]

42 HIA 259 said that they shared a toothbrush between seven or eight boys and they only cleaned their teeth once a week:

> "It was disgusting but that is the way it was".[56]

The sharing of toothbrushes was denied by the Order.[57]

43 HIA 24 commented on the use of carbolic soap. HIA 33 noted that as his number was 128 he always came near the end of the queue, and since the bathwater was never changed, it was cold and dirty by the time he was due to bathe.[58]

44 Bathtime routines remained institutional when girls were admitted. HIA 423 who was in Nazareth Lodge from 1964 to 1970 wrote:

> "At bath time, we were stripped and made to stand in a line. We had to walk up and down the wooden steps [as the baths were high-sided] and then we were put in a big tub. The nuns used scrubbers, like those used to scrub a floor, to bath us and we all had to share the same bath water. There would be one nun on each side of us. They would grab us by the back of the hair and pull us down under the water to get the carbolic soap out of our hair. There was always an institutional smell that we couldn't get rid of. We would be really red when we got out because of the scrubbing brush. All the children wanted to be the last to get bathed because whenever we got out of the bath we were made to stand, still naked and without any towel, until everyone was bathed. We could be left standing naked for up to an hour before we were allowed to get dressed".[59]

55 SNB 256.
56 SNB 543.
57 SNB 1941.
58 SNB 1641-1642.
59 SNB 741-742.

45 HIA 5 said that in the 1980s bathtime was "horrific". Girls and boys had to queue together naked for their baths; he had never seen his brother naked before. A member of staff stood in the bath and held his shoulders down, one nun held his legs, while another nun poured a bucket of cold water and Jeyes fluid over him. Their mouths were washed out with carbolic soap to make their souls clean.[60]

46 Sisters who were consulted had no recollections of children being required to line up for baths, and the Congregation:

> "would not accept that there was any deliberate policy or policy requiring children to stand in a line with other children without clothing".[61]

They accepted that, particularly in the earlier days, bath water would have been shared, as was the practice in many families at that time.[62] The system of bathing used in Nazareth Lodge was presumably devised when the home was first opened and very large numbers of boys had to be supervised. Even in the 1950s it should have been possible to change the bath water more frequently than as described by the witnesses, and if it was necessary to economise, showers could have been introduced, reducing the likelihood of sharing infections through the dirty bath water and shared sheets for drying. By the 1950s, the system was contrary to the approach outlined in the 1952 Home Office Guidance, which said that children should be taught to bath themselves and that there should be clean water for each child.[63] In view of the minimal staffing of the home at that time it is unsurprising that such an outdated system was maintained, but this represented poor childcare practice. **The bathing system should have been abandoned and its continuation represented systemic abuse.**

Jeyes Fluid

47 Many witnesses recalled the use of Jeyes fluid when they were bathing. HIA 159 said that hair was washed on Fridays in a long sink like a horse trough, using Jeyes fluid, and that their underpants were examined for soiling. Three boys were made to sit in a cold bath for an hour.[64] By contrast, HIA 142 recalled the water being "always scalding hot" and that he was scrubbed till his skin was raw.[65] HIA 159 thought bathing was less frequent:

60 SNB 037.
61 SNB 1507.
62 SNB 1507.
63 HIA 475.
64 SNB 594.
65 SNB 284.

> "We also had a bath once a month and our hair was washed once a week in a solution of Jeyes fluid to keep us free of nits and other hair infections".[66]

HIA 307 said that Jeyes fluid was put in baths, and it "stung like hell". It was thought by the boys that the Jeyes fluid was used to deal with lice.[67]

48 The Sisters accepted that a small amount of Jeyes fluid might have been used to prevent outbreaks of head lice, body lice and scabies, but did not accept that Jeyes fluid would have been used in bathing as an alternative to soap, suggesting that it was its pervasive smell when used to clean bathrooms that witnesses recalled.[68] This explanation would not account for the stinging sensation which witnesses reported, and the witnesses who recalled its use in bathing were persuasive.

49 There is no doubt that in running a home for over a hundred boys it was necessary to apply high standards of hygiene, and there was always the risk that newcomers or children on visits home could introduce lice or fleas. Cleanliness and regular checking were therefore important, but other treatments were available. Jeyes Fluid was a very strong detergent for use on floors and tiles.

50 **When Jeyes fluid was first developed in 1877 it was used for many purposes, but by the 1950s it should not have been used in baths or for hair washing. This practice was well out of date and in our view its use amounted to systemic abuse.**

Bedwetting

51 The first reference in the records to bedwetting arose from a complaint in 1927 that a boy had been punished for wetting his bed. A representative of the Ministry of Home Affairs told the sister and manager of the home:

> "Punishment is not the proper way to deal with these cases, but on the contrary is liable to make them worse".[69]

Advice from the Ministry in those days would usually have been taken seriously, but the evidence of witnesses suggests that bedwetting continued to be punished.

66 SNB 32188.
67 Day 84, pp.5 to 6, SNB 099.
68 SNB 1508.
69 SNB 13660.

52 HIA 204, referring to the 1930s, said:

> "When I wet the bed I was punished the next morning by being taken to the bathroom by the older boys, where they threw buckets of ice cold water over me. I then had to kneel outside [SR 118's] room. When she came out she made me lie down on the floor and she beat me on the backside with a strap. This went on for years".[70]

Nothing was done to correct his enuresis and he continued wetting the bed after he had left Nazareth Lodge.[71]

53 Although not enuretic himself, HIA 408 confirmed HIA 204's account:

> "The boys who wet the bed were treated very badly by [SR 118]. All the boys in the dormitory were brought to the bathroom to watch the bedwetters get punished. They were placed in a cold bath, regardless of whether it was winter or summer. There would be an older boy who poured buckets of cold water over the boy's head. It was so cold the boy in the bath would be unable to breathe. [SR 118] would then get the boy out of the bath and put him on the red tiled floor. She would hit him on the behind and it would sting because he was cold. If he turned over she would put her foot in his groin and hit him again. I never wet the bed so I was never punished in this way, but I was made to watch the same four or five boys being punished in this way nearly every morning".[72]

HIA 99 also described his personal experience of the same treatment in detail.[73]

54 Even when girls were admitted to Nazareth Lodge, punishment was said to have continued. HIA 423 said that she wet the bed once and was beaten and called dirty:

> "For the next week, when I was in bed, the nuns would tie my feet at the ankles to the bottom of the bed. It was an iron bed with poles and they used bits of rag to tie me to it. My feet would be freezing and the nuns would come back to check that I hadn't covered them over".[74]

55 The Order did not accept that this happened.[75] However, the Sisters did accept the complaints about the treatment of bedwetting. Sr Brenda said:

70 SNB 305-6.
71 Day 82, p.12.
72 SNB 220.
73 SNB 275.
74 SNB 741.
75 SNB 1951.

> "The sheer number and consistency of these complaints make it very difficult to deny that events such as those described did actually happen".[76]

She suggested that the treatment of the children:

> "...was done out of ignorance of the issues behind the problem and a belief that the child could just stop the bedwetting if he or she wished",

having perhaps considered the children rebellious or mischievous. Sr Brenda suggested that the punishment of being bathed in cold water reflected the need to be washed before attending school and a shortage of hot water.[77] This does not explain the cruel treatment meted out by SR 118.

56 It is hard to understand why such methods were used, especially as it had been acknowledged at Nazareth Lodge as far back as 1927 that punishing enuresis did not cure it. Children who wet their beds needed to be treated sensitively; by contrast, the use of terms by the sisters such as "fish" for the enuretics was presumably intended to be demeaning. It must have been apparent to SR 118 that her approach was ineffective if she had to keep on punishing the same four or five boys. **There was no justification for SR 118's cruel conduct in punishing bedwetters, which amounted to systemic abuse.**

Health care

57 In their final statement the Congregation quoted four anonymous cases and twenty witnesses who described their health care at Nazareth Lodge. They also highlighted the evidence that medical officers had been appointed to the home and had visited regularly.[78]

58 After an accident in which his eye was damaged by a privet hedge, HIA 159 had the eye removed in hospital and an artificial eye was fitted. As an adult he was classed as disabled, which made getting jobs difficult.[79] He had further spells in hospital while he was at Nazareth Lodge, with an infected knee, a broken leg and a serious cut to his hand. The treatment he received while at Nazareth Lodge appears to have been appropriate.

76 SNB 1510.
77 SNB 1510.
78 SNB 100143.
79 SNB 594.

59 More than one witness spoke about being ignored when they were unwell and confined to bed. HIA 183 said that no one checked on him or brought him food, and he had nothing to eat,[80] for example, and HIA 307 said he was left in isolation and no one spoke to him for days.[81] If this happened it was poor childcare.

60 HIA 297 recalled that a nun treated a boil on his leg, but could not remember seeking a doctor or dentist during his four years at Nazareth Lodge.[82] His medical records indicate that he had audiology tests and a tonsillectomy in Belfast City Hospital. HIA 33 said that the doctor was never called and that if a boy caught a cold SR 118 administered a spoonful of castor oil.[83] Even as late as 1980, HIA 10 reported that she had scars on her neck from the use of the silver lice comb and that she had seen other girls bleeding.[84]

61 We are inclined to believe the records, rather than the witnesses' recollections. It is not surprising that inspections by medical officers were not recalled, as they probably carried little significance for the children and were viewed as part of the home's routine. The accounts suggest that, other than boys being left in isolation, the health care provide at Nazareth Lodge was satisfactory.

62 One female witness, HIA 363 alleged improper conduct on the part of a General Practitioner. Since the alleged behaviour was said to have occurred in the doctor's surgery it was outwith the remit of the Inquiry, and if the matter were to be taken further, it would need to be investigated by the Health Authority and the General Medical Council. It is not the Inquiry's role to reach conclusions on specific cases, but in so far as HIA 363's allegations related to failure on the part of the Sisters to notice her distress, the evidence of the witness was discrepant from the detailed health records maintained by the home. We concluded that there were no grounds for determining that there had been systemic abuse.

Clothes

63 Although clothing was individualised in the later years, for most of the period covered by the Inquiry's remit, the Sisters relied on donations from

80 SNB 523.
81 SNB 098.
82 SNB 353.
83 SNB 1642.
84 SNB 749.

the community or from supportive businesses, or they made the clothes in their workroom. In consequence, although there was no uniform as such, as HIA 87 commented, all the boys dressed the same and were easily identifiable as home boys. The styles, however, clearly varied from time to time, depending on what was available.

64 HIA 24 said that in the 1940s they wore shorts and orange jackets.[85] HIA 87 was given a one-piece boiler suit; shorts, a shirt and other smarter clothes were issued if boys were going out of the home.[86] HIA 247 said that there was no official uniform but all the boys wore shorts and similar tops. HIA 89 said they wore same clothes every day, and had shorts until they were ten or twelve years old. According to HIA 422 the boys had a brown corduroy uniform and short trousers.[87] HIA 110 said that they had "wee shorts and a t-shirt."[88]

65 This was not just a matter of fashion or individuality. Because stocks were limited, clothing was often ill-fitting. HIA 89 said that the clothes were satisfactory, but his underwear was too tight. HIA 408 said that he wore shorts and boots but no socks in the 1930s. Wearing boots without socks gave him blisters and he says that he has continued to suffer foot problems caused by the badly fitting boots he had to wear when at the Lodge. HIA 99 wore sandals mostly; he had to wear tight shoes once and says he was crippled. HIA 89 had holes in his shoes.

66 The Sisters said that they provided the best clothing possible and the children were provided with a full school uniform. They did, however, have to rely on hand-me-downs and donations from firms.[89] At a time when there was widespread poverty, and children in the community often wore hand-me-downs, it is not surprising that the quality of clothing and footwear was poor in the early years. The Order in Belfast was dependent on a poor community for its income and for the donation of clothing and footwear; no doubt some of the apparel it received was already well worn. However, from the 1950s onwards, the Sisters could have obtained fees from the welfare authorities for the upkeep of the children, and they were slow in accessing these resources. From the 1960s onwards it should not have been necessary for children to wear old or ill-fitting cast-offs.

85 SNB 419.
86 SNB 255.
87 SNB 214.
88 SNB 501.
89 SNB 1511-1512.

67 As social workers became more involved, grants for clothing became available and they (or the children's keyworkers) took children to the shops to buy clothing with their allowances.[90]

Numbers and Names

68 The Sisters allocated numbers to the boys, ostensibly for the purposes of identifying their clothing, and this practice was clearly preferable to having a common pool of clothing. Many of the witnesses recalled their numbers, and it appears that their numbers were at times used for other purposes. HIA 183 said he was never called by his first name, but was always known by surname or by his number, 66, for clothes. Other witnesses provided similar evidence.

69 The Congregation said that there was no specific policy on the use of numbers, which was seen as a pragmatic way of dealing with laundry. Nor was the practice discontinued at any particular time.[91] Throughout the period of the Inquiry's remit, if the Sisters were trying to create an alternative home life for the boys, it would have been best practice for staff to use first names in talking to children, and in so far as numbers were used for other than practical purposes, such as the allocation of clothing, this would have represented an institutional approach to care. It is our impression that the use of numbers rather than names happened on occasion, but there has been insufficient evidence to be certain that this was standard practice.

Food

70 Feeding a large number of boys with limited resources must have been a challenge for the Sisters, despite the presence of the farm and the kitchen garden, especially as growing boys are often hungry. The food provided appears to have been basic and without much variety. Understandably it was when the food fell below acceptable standards that the witnesses recall what was on offer. In the Congregation's final statement they quoted approving inspection reports from the 1930s and 1940s and the statements of witnesses who found the food acceptable.[92] The most approving observations, though, relate to the last decade before the home closed, though even then there were critical observations.[93]

90 SNB 100257.
91 SNB 1506-1507.
92 SNB 100130, 100135, 100137, 100138.
93 SNB 100133, 100134.

71 HIA 408 recalled that in the 1930s the boys were made to eat food which was "smelly and bad". Breakfast was porridge with salt and sour milk, and there was a cup of hot milk and half a slice of bread and dripping at 11am. When he took breakfast to SR 118 he stole a bit of bacon as he had never seen it before.[94] HIA 422 said that the boys used to take bread out of a bin in the back yard and if there was a fire to burn rubbish they toasted the bread.[95] HIA 99 said the food was "not good". He alleged that he was forced to eat a rotten potato by SR 118. He said that the volume of food was satisfactory, but noted that the older boys dined with the nuns and had meat.[96]

72 Several witnesses reported that they had been hungry and they tried various measures to obtain additional food. HIA 408 said the boys had steamed potatoes, and that they scavenged peel from the dustbin. HIA 89 said he was always hungry and that food was of a poor standard. HIA 159 said that:

> "Most of the fruit ...was stored in the large barn at the far end of the old people's home, which was behind the baby home. Small groups of boys used to go down at night and nick a few bananas and apples".[97]

He said that he was forced to eat the stolen apples after a raid on the store and he had a struggle not to throw up.[98] HIA 183 said the food was not great - mainly stew and porridge, and he was so hungry that he sneaked into the kitchen and stuffed himself with bread.

73 By contrast, HIA 110 said that on the day of their first Holy Communion they had a fried egg; it is noteworthy that this was a special treat.[99]

74 From 1975, with the new kitchens in the units, the food improved and the children were given supper.[100] However, HIA 363, who was admitted to Nazareth Lodge in 1977, said the food was still terrible; if not eaten, it was brought out the next day, and she was force-fed when the food was two or three days old.[101]

94 Day 82, p.42.
95 SNB 212.
96 SNB 276.
97 SNB 32183.
98 SNB 596.
99 SNB 501.
100 SNB 1975.
101 CLO 1005.

75 According to Sr Brenda the Sisters attempted to provide the best food they could, taking account of factors such as rationing. She said that the nuns ate the same food as the children, and when there was a shortage it was the sisters who went without.[102]

76 It is apparent from the evidence that the boys were at times hungry, that there was little variety, that there was probably very little fruit for the children and that at times the quality of food was poor. However, it is likely that there were many people in the community who were in the same position, especially in the post-war period when food was still rationed. On balance, without denying any of the witnesses' evidence, we are inclined to accept that the Sisters tried to provide a reasonable diet within the limited resources available to them. However, there appear to have been times when the food failed to meet minimum standards in terms of both quality and quantity. As with clothing, the standard of food could have been improved earlier if income had been received from the welfare authorities.

Force-feeding

77 HIA 110 said they were hit across the face by the civilian staff if they did not eat the food.[103] HIA 142 said that he was force-fed held in "a clamped position" to keep him still and make him swallow, and he attributed current eating problems to this treatment.[104]

78 HIA 141 alleged that SR 29 had force-fed her with Brussels sprouts, which made her vomit all over SR 29, who slapped her face.[105] HIA 225 said he was force-fed turnip:

> "I did not want the turnip but this person pushed it into my mouth and hit me around the face and made me swallow it. This made me vomit and she then made me eat the vomit".[106]

The Order did not accept that force-feeding took place, but when this was put to HIA 225 when he gave evidence he was adamant that it happened and remembered it vividly. HIA 225 said:

> "...on this occasion I said, 'I don't like it. I don't eat turnip', and I was told to eat it and I wasn't going to eat it, and that's when...I had a

102 SNB 1511.
103 SNB 501.
104 SNB 284.
105 SNB 110.
106 SNB 531.

spoon put in my mouth, and I said, 'I will be sick', and it continued, and I was sick, and she lifted a piece of what I threw back up and put it back in my mouth and slapped me round the face. I mean, I can't imagine what the Congregation may feel about that. That is up to them, but I know how I felt about it."[107]

79 The exasperation of staff when boys refused to eat food is under-standable, as children were expected to eat everything, not only because of the waste if it were uneaten, but also because in residential care refusal was seen as a symbolic rejection of what the staff offered in their parental role. The rejection of food is often one of the symptoms that all is not well in a children's home. However, force-feeding sets up a confrontation which staff may lose, and it does nothing to persuade the child to like the food s/he has refused or form a closer relationship with the staff involved. This practice was therefore unacceptable in residential childcare. **We accept that force-feeding took place and it constituted systemic abuse.**

Punishments

80 SR 30 said that there was no disciplinary policy in the later 1970s, and children were sent to their rooms or deprived of privileges, for example when a boy flushed a hamster down the toilet.[108] SR 29 said that the responsibility for discipline lay with the sisters in charge of the units:

> "…the main punishment for children who had misbehaved would have been having their pocket money reduced or taken off them for a short period, they could have been asked to do extra chores such as helping with the washing up or setting the tables and cleaning and polishing shoes, their access to the TV could have been withdrawn or not being allowed to watch movies. On some occasions they would have been sent to their rooms or could have been, what is now known in modern terms 'grounded' and not being allowed to go into town to the cinema or events like that".[109]

Such punishments would have been quite appropriate in residential childcare at that time, but they contrast sharply with the witnesses' descriptions of physical abuse.

107 Day 87, pp.38 to 39.
108 Day 93, p.117.
109 SNB 1561.

Activities

81 On Saturday mornings there were further chores to be undertaken, but the children had free time in the afternoon. HIA 89 was at Nazareth Lodge from 1943 to 1953 and he said that:

> "Other than a football there were no toys to play with. We made up our own games".[110]

In contrast, HIA 159 said that there were swings, sand pits and a large climbing frame. They played tig, hide and seek, marbles and hopscotch. They also had hoops, tricycles and scooters.[111] In the later years they went swimming and attended a youth club, brownies or scouts.[112]

82 It was on Saturdays that the "sweetie men" called, bringing their guitars; they also accompanied the boys at holiday times.[113] Since all the staff, other than the handymen and visiting priests, were women, the involvement of male volunteers who could provide role models would have been welcome. Occasionally the boys were taken out for a walk in the neighbourhood, but the witnesses who spoke of the walks did not generally have happy memories. HIA 87, for example, recalled that in the 1940s Sunday walks in Ormeau Park were "like open jail", as the boys were not allowed to stop to play or talk to anyone. HIA 159 said:

> "On Sundays in the summer months we would go out for a long walk to the Ormeau Park on the Ravenhill Road, and it could get very hot in these little brown uniforms".

83 Other trips out were more memorable. There appear to have been regular trips to the cinema and the swimming pool and occasional trips elsewhere. DL 40 recalled that all the chaplains at Nazareth Lodge were kind and took the boys out for day trips in their cars, for example to Portrush and Portadown.[114] HIA 21 recalled being taken to the pictures on Ormeau Road, and going to the swimming pool on Thursdays.[115] HIA 159 remembered seeing *The Ten Commandments* from the circle, and during the break the boys had ice-cream and sweets. They also visited Dublin Zoo, and a circus at the Grand Opera House.[116] In addition to the

110 SNB 487.
111 SNB 32187.
112 SNB 1590.
113 SNB 503.
114 SNB 1872.
115 SNB 634.
116 SNB 32187.

cinema trips, they had films in the hall - religious ones, comedies, and cowboys and indians, according to HIA 159.

84 An activity which brought back happy memories and a sense of pride was the music. HIA 159 wrote:

> "[SR 152] was in charge of the choir. We used to practise upstairs in the corridor at night when it was near Christmas time, and to keep our voices clear and warm, [she] used to bring up a large pot of very hot water with loads of jam in it. We usually had two cups, then we were singing again".[117]

85 The boys' choir was used for special occasions:

> "...we got dressed up in our little brown uniform and sandals for this opening day [St Joseph's Baby Home] and...on the feast of Corpus Christi we would walk from the chapel down the avenue saying the Rosary and finish beside the statue and sing some hymns. We also wore our suits when we went away to Bangor, Dublin, as part of the choir, or Belfast city to make a record of some Christmas carols..."[118]

86 HIA 204 said that he was selected to sing and do Irish dancing at concerts organised for visiting nuns and priests, sometimes having to dress as a girl, and sometimes having to present chocolates to the visitors.[119] HIA 247 also mentioned winning a cup for Irish dancing.[120]

87 HIA 307 said that singing was one of the few good things about the Lodge. He had a good voice, they nurtured his ability and he enjoyed it, though he felt that he was used by the nuns at fundraising events. There was a lot of practising to get things right and the nuns encouraged him to have a sense of pride; he was the lead singer and actor at the time.[121]

88 In large homes such as Nazareth Lodge activities were important as ways of occupying children, and thus avoiding misbehaviour, as well as giving them positive experiences and, in the case of music, developing their talents. The Sisters appear to have made good use of their community contacts, and it is clear that the opportunities to sing and dance were much appreciated.

117 SNB 32186-32187.
118 SNB 32188.
119 Day 82, pp.11 and 17.
120 Day 84, pp.125 to 126.
121 Day 84, p.21.

Birthdays

89 Birthdays were generally not celebrated, at least in the earlier decades, and some children did not know when their birthdays were. HIA 99 said that he did not know what birthdays were until he was older. HIA 422, however, said that when he was eleven there was a party for him in the dining hall,[122] and in the 1970s HIA 210 had a party every year to celebrate his birthday.[123] SR 29, who was at the home in the late 1970s and early 1980s, said that children had "small parties for their birthdays".[124] As stated to the Hughes inquiry, there is a reference in the log on 2 January 1976 to the combined celebration of two boys' birthdays.[125]

90 Even in a large home it should have been possible to make each child's birthday a special day, and the failure to celebrate each individual once a year in the earlier decades indicated the institutional nature of the childcare at Nazareth Lodge. The fact that children did not know their birthdays also indicates lack of discussion about personal matters.

Christmas

91 Christmas was recalled as a time of mixed excitement and disappointments. The main memory of Christmas time was the parties which children were invited to attend. They were held at big businesses such as Mackie's factory and Kennedy's bakery. A witness said that these parties were the only times that the boys at Nazareth Lodge and the girls at Nazareth House saw each other. HIA 247 said that at the parties, they were spoiled with cake and sweets.

92 Attendance at the parties was shared out, but selection also appears to have depended upon the behaviour of individuals. HIA 87 said:

> "Only the good boys were allowed to go out on trips or to the Christmas party [at Mackie's Iron Factory] but it was difficult to be good enough for the nuns, because they were always wanting more work out of us or finding fault with anything we had done. We could never please the nuns".[126]

93 There were other special events according to HIA 408, such as a visit to the cinema for a Mickey Mouse film and the Midnight Mass on Christmas Eve. HIA 99 said that plays were put on at Christmas. HIA 141 said that

122 Day 85, p.41.
123 SNB 600.
124 SNB 1562.
125 SNB 100154.
126 SNB 256.

she was given a present when sitting on Santa's knee for a photograph, but the nuns removed the present immediately afterwards and she never saw it again.[127]

94 Several witnesses recorded getting presents on Christmas Day - an orange and an apple and three sweets according to one witness, a bun and an orange according to HIA 89, and apples and oranges but no toys according to HIA 87. HIA 99 said that the boys were given toys to play with on Christmas Day but they were not allowed to keep them. HIA 21 said that Christmas time was exciting, but toys had to be handed back the next day, causing resentment:

> "One year I received a toy milk float with churns and it broke my heart when I had to give it back".[128]

The Order did not accept that this happened.[129]

95 HIA 87 said that Christmas was also a time when benefactors visited, and so things were polished and better pillows and quilts were put out. HIA 21 said that on Open Days lots of people visited and gave them sweets.[130]

Education

96 The Nazareth Lodge primary school was within the grounds. HIA 408, who was at Nazareth Lodge in the mid-1930s, said that there was an emphasis on religion and Latin at the expense of other subjects such as geography and maths.[131] However, the nuns never explained the meaning of the Latin they used to the children.[132] HIA 16 wrote:

> "The standard of education was poor in the home. The school was in the [grounds of the] home. I recall I was never given homework and there was very little structure to the classes. I felt that we were taught very little."[133]

97 HIA 21 said that there were four classrooms and four teachers: SR 34, SR 47, SR 156 and NL 63, a lay teacher. He felt that they were all good teachers, though two of them NL 63 and SR 34 used the strap. He reported that no home work was required of the boys, and in consequence, their

127 SNB 109.
128 SNB 634.
129 Day 84, p.79.
130 Day 84, p. 83.
131 Day 82, p.40.
132 SNB 222.
133 SNB 396.

attainments were poor, which later affected their employment prospects, for example in failing to fill in application forms.[134]

98 HIA 99 said that in his time they had civilian teachers, who concentrated on the brightest children, but he had no complaints about them, as he learned to read and write. HIA 183, on the other hand, found the education poor, and he could not read or write when he left. HIA 159 said that:

> "...after 1954-5 a dozen boys who could not pick up schooling very quickly were sent outside to a special school for slow learners".[135]

99 There were, however, boys who considered themselves intelligent, but who felt that the schooling had failed them. HIA 247 took a technical examination with another resident, NL 287. They were expected to succeed but they had been taught the wrong things, so they failed and were sent instead to Rubane. Unknown to HIA 247, the Sisters had made unsuccessful efforts behind the scenes to get him a place in a Belfast secondary school.[136]

100 HIA 33 said that he was doing well academically but was never given the option of furthering his education; instead he was directed to work at the front door, scrubbing the steps, polishing the long corridor, answering the door and providing soup to vagrants who called.[137]

101 HIA 225 saw himself as intelligent and felt that if he had had a normal education he would have passed the 11-plus (as his younger brother did) and gone to grammar school. As it was, he considered his preparation for the 11-plus "woeful" and he failed. To make matters worse, NL 4 announced the result to the group, labelling HIA 225 "stupid", which hurt him more than any beating. He said that he had a chip on his shoulder thereafter.[138]

102 HIA 132 concluded:

> "The education was bad. They didn't treat you well because they thought we were orphans and wouldn't get anywhere in life anyway. They were right. Without an education you can't get anywhere and you end up in low paid jobs..."[139]

134 SNB 635.
135 SNB 32190.
136 Day 84, pp.126 to 127.
137 SNB 1642.
138 SNB 534, Day 87, p.55.
139 SNB 586.

103 In September 1974 St Michael's was opened, combining both the Nazareth Lodge and Nazareth House schools. It had a Board of Governors, and according to NL 63 the content of its teaching was less religious.[140]

Holidays

104 During the summer some children went to stay with members of their family, and others were placed with foster families. These placements are considered below. The children for whom no placements were found went on holiday as a group to places such as Ballyhornan, where they took up residence in some RAF huts near the seaside. HIA 159 said that during the summer they went to Tyrella beach where they camped in tents like giant wigwams. Later the home spent holidays at Waterfoot.[141]

105 To some extent the lifestyle on holiday replicated that at Nazareth Lodge, but it seems that the atmosphere was generally more relaxed. Most of the boys have fond memories of their holidays. DL 40 said they had such a great time at Ballyhornan, making friends with other holiday makers,[142] that he wanted his ashes scattered there.[143]

106 SR 46 said that she might have been too strict, but that she had been affected by a serious accident that happened to a boy when on holiday. He had been allowed to go and buy maggots climbed on rocks and fell 70 feet, suffering brain damage, such that SR 46 was more restrictive thereafter.[144]

Family Contact

107 Parents typically visited children at weekends, but mid-week visits also took place. Some children also returned home for weekends or holidays. There were some concerns mentioned in the evidence. HIA 24, for example, said that his mother visited him a few times while he was at Nazareth Lodge, but when she visited he was warned by the nuns to say nothing derogatory about them.[145]

108 The draft inspection report in 1983 was critical of arrangements for parents to visit and suggested that greater efforts should be made to make them feel welcome. Although the inspectors were told that parents were welcomed, in practice very few visited, though family contact was

140 Day 110, p.5.
141 SNB 32184.
142 SNB 1873.
143 Day 95, p.58.
144 SNB 1590, Day 93, pp.35 and 36.
145 Day 83, pp.67 and 68.

maintained through the children's weekend visits home.[146] When the smaller units were established, rooms were set aside for visitors. Overall, this was not a point of contention.

Personal Possessions

109 Witnesses expressed considerable strength of feeling about things which they considered to be theirs and which they allege the nuns removed and they never saw again. This included the clothes they wore on admission, presents of clothing brought in by relatives, toys which they were given at Christmas and money given to them by foster carers.

110 HIA 10 said that her mother sent her a Barbie doll with a horse and riding gear, but she was only allowed to play with it on Christmas Day and then it was taken away.[147]

111 There were some complaints that parcels sent to boys did not reach them. HIA 159 said that the nuns prevented him from having contact with his mother and his aunt. Sandals sent by his mother for him were given to NL 71 by the nuns, and he never received a promised birthday present. Later he was told that mail had been sent to him, but he had not received it. He said that he saw lots of toys and parcels in a room above the entrance.[148]

> "Some boys never received the parcels sent to them from their mothers or aunts".[149]

Sr Brenda stated that there was no policy of withholding letters from children, though in some cases the sisters might have done so if it was thought that family news would upset a child, or if a letter were being looked after for a small child.[150] The 1952 Home Office Guidance said that normally the staff should not read children's letters.[151]

112 The Sisters denied that toys would have been removed from children, and did not understand where this memory came from.[152] As NL 5 pointed out, toys that were donated were "not always new" and NL 151, the handyman, had to take some to the dump.[153] NL 4 said that children

146 SNB 14813.
147 SNB 748.
148 SNB 595.
149 SNB 32189.
150 SNB 1509.
151 HIA 476.
152 SNB 1508.
153 SNB 80035.

had no personal belongings but that toys were owned communally.[154] This observation was consistent with the complainants' evidence. If this were the case, it reflected poor childcare, as children should have been encouraged to develop their individuality, and having personal possessions was one important aspect, indicating their personal attachments, tastes and interests.

113 During much of the period in question it was considered very poor childcare practice to intercept mail or parcels unless there were strong reasons that a child would be in some way put at risk if staff did not intervene. It is possible that the Sisters' practice was long established and that they diverted items sent to children in order to ensure that children with generous parents did not receive appreciably more than those without families or whose parents were less well off. The Sisters themselves had had to sacrifice personal possessions voluntarily on entering the Order, and they should have appreciated how much personal possessions such as items sent by parents mattered to the children in symbolising that their parents still cared for them.

Foster Care

114 Some of the boys had been in foster care before admission to Nazareth Lodge. One example was HIA 307 who had developed a close bond with his foster mother. She visited him monthly and complained to the Reverend Mother that HIA 307 was not being cared for properly. Her visits were stopped. HIA 307 was later told by a boy who had been with him in the foster home that she was told that HIA 307 had gone to a good home and she need not visit again. The other boy stayed with her until he was 21 and got married, and HIA 307 felt that life would have been different for him if he had had the same opportunities.[155] He said:

> "That lady was the one person in my life that ever gave me any affection and I still feel her loss today. I have no doubt that the nuns lied to her because she was critical of their neglect and low standards of care. The nuns took from me the one important emotional attachment I ever had in order to protect themselves from criticism. If that relationship had been allowed to continue I think my life would be quite different."[156]

154 Day 113, p.54.
155 Day 84, pp.18 to 19.
156 SNB 100.

115 A large number of boys who could not spend the summer with their families were placed with families for occasional weekends or for summer breaks. These placements did not provide foster care as it is known today. It appears that the Sisters contacted priests, who sought volunteer families from their congregations. Although Section 2 of the Children and Young Persons Act 1950 laid down a requirement that written approval for any placements should be sought from the welfare authorities, this did not become standard practice until much later.[157] The children at Nazareth Lodge had been placed in care voluntarily, so that the welfare authorities were not involved in overseeing their care and were unaware of their existence. The Sisters were presumably continuing long-standing practice. The result, though, was that the families were not properly scrutinised, and the failure to assess them left some of the boys at risk.

116 It was in July 1972 that Bob Bunting, Assistant Director in the Belfast Welfare Authority, wrote to the Mother Superior to ask her to ensure that couples and families were approved before children in the Authority's care were allowed to visit them, even for day visits.[158]

117 HIA 21 went to foster homes at weekends, but said:

> "Ironically in most cases the boys couldn't wait to get back to the Lodge; after all it was our home".[159]

He visited a family for weekends, but "it was good to get back 'Home' to the Lodge".[160] HIA 247 visited a well-off family who wanted to foster him but they were refused, perhaps because of parental objections.[161]

118 A woman took HIA 183 out once a month and a family took him for two or three weeks in the summer.

> "I thank God for those short breaks away as they are the only happy times I remember from my childhood".[162]

On returning to Nazareth Lodge, the sister took sweets and money off him. He was not worried about the nuns having the money as he had nowhere to spend it. In oral evidence HIA 183 said that he was still in touch with both the woman, who was now 85, and with the family. He really looked

157 HIA 165-166.
158 SNB 9149, 100281.
159 SNB 634.
160 Day 84, pp.80 and 81.
161 Day 84, p.129.
162 SNB 523.

forward to holidays with them.[163] HIA 247 also said that he was still in touch with a family who had had a farm at Kilkeel, where he had had "a great time" during the summer.

119 HIA 259 was first sent to a farm, which he did not like much. He was then sent to a foster family who bought him clothes, a bicycle and football boots. However, on his return to Nazareth Lodge, the clothes disappeared, NL 5 gave the boots to another boy and the bicycle was replaced with an older one; thereafter the foster parents kept things they bought for him at their home.[164]

120 HIA 225 spent Christmases with a family who wanted to adopt or foster him, but his father would not allow it. HIA 225 said, "It was my only experience of real family life", and he remained close to them till they died.[165]

121 HIA 41 said that when he stayed with a family for a weekend, a man talked to him sexually and groped him when he sat on the man's lap to drive his car on a public road. HIA 41 had been selected to stay with this family when another boy had refused to go.[166]

122 Some of the placements, as described above, were highly appreciated by the boys, as they offered a chance to experience family life and they led in some cases to life-long friendships. Arranging a large number of these placements every summer must have entailed a lot of work for the Sisters, and despite their failure to have the families properly checked and some consequent exploitation and abuse, the holiday foster care system as a whole has to be seen as one of their successes.

123 As social workers became increasingly involved, foster placements were arranged for children to move to as permanent placements. NL 190 described the problems of recruiting foster parents in the mid-1970s. At that time there was no specialist fostering team and it was for individual social workers to recruit foster carers. She wrote:

> "The social worker would place an advert in the newspaper, follow up any responses, complete a home study and obtain approval from senior staff".[167]

163 Day 84, pp.61, 70.
164 Day 88, pp.123 and 124.
165 SNB 533.
166 SNB 442.
167 SNB 6071.

This task was additional to their full caseload, and each social worker requiring a placement had to learn the procedure. NL 190 was working with HIA 210 and his brother, who were members of a family of thirteen, eleven of whom were in long-term care, split between different children's homes. She felt that the splitting of the family was not good practice but was inevitable through lack of provision; the siblings, as it happened, were not enthusiastic about meeting.[168]

Work Experience, Discharge and Aftercare

124 In the period when Nazareth Lodge was an industrial school there was a requirement that the school found employment for boys who were funded by the state. In the 1930s, when HIA 408 was aged twelve, he was picked to work on a farm run by a couple, NL 82 and NL 83. He recalled that twelve boys were lined up for NL 83 to choose from, and HIA 408 thought he saw money passed by her to the sister. He said that he felt he was "sold like a slave".[169] He alleged that he worked every day from 6am to 10 pm on the farm without pay for two years; he never had a day off and he spent a lot of time cleaning eggs.[170]

125 HIA 87 finished school at 13 and was given jobs to do around the home, such as looking after little children and growing vegetables. He was made a charge boy working with the infants group, helping by feeding them, for example.[171] HIA 99 confessed to the priest about all that had happened to him while he had been at Nazareth Lodge, and he was moved the following week for adoption by a couple who had a farm.

> "I was given no preparation for leaving Nazareth Lodge and it just happened out of the blue".[172]

126 If these recollections are accurate, they represent systemic abuse. HIA 408 would have been of school age; payment for such an arrangement would have been quite improper; and the conditions which he described were exploitative. This is, however, the only evidence which we have received describing such practices, and without further corroborative evidence to indicate that was commonplace it is insufficient for us to make a general finding of systemic abuse.

168 SNB 6070.
169 Day 82, p.49.
170 Day 82, p.50.
171 Day 83, pp.47 to 48.
172 SNB 280.

127 In 1950 the Nazareth Lodge Welfare Committee was established, with the Bishop of Down and Connor as its Patron. To judge by its reports and minutes it provided impressive services for boys who had left Nazareth Lodge, for girls a paid welfare officer based at premises in Great Victoria Street, Belfast, and a number of volunteers. The services offered included help in finding employment and accommodation, and the provision of clothing. The Committee raised a considerable amount of money, for example through organising day trips to the Isle of Man.[173]

128 When Rubane opened in 1953, the boys were usually transferred there at the age of eleven. There was generally no need, therefore, for the Sisters to obtain employment for school-leavers or to provide aftercare. A small number of boys did stay on, but this was to enable them to attend schools in Belfast as they were showing some academic promise.

129 From 1953 onwards the transfer to Rubane took place each autumn. HIA 56 wrote:

> "Once we turned eleven we were taken in groups of about ten or twelve boys in a minibus to Rubane. …It happened very quickly and there was no preparation".[174]

Staff at Rubane commented on the lack of background information which they received.

130 A number of boys were discharged from Nazareth Lodge by being sent to Australia. This is dealt with in Chapter 6. In all, twelve applicants who had been sent to Australia from Nazareth Lodge gave evidence to the Inquiry.

131 School-age boys were still given tasks that entailed responsibility within Nazareth Lodge. In the early 1970s HIA 41 was given the job of minding the front door out of school hours from 4pm to 10pm; this entailed answering the door, welcoming visiting priests, brushing the paths in the garden and nuns' graveyard, giving beggars tea and sandwiches, and locking up. This role gave him both responsibility and a measure of freedom. NL 5 denied that HIA 41 undertook this role, saying that it was "pure fantasy", but it was mentioned by SR 30 and in social work records.[175]

132 HIA 132 said that his elder brother, who had acted as his protector, was adopted, and he left without the opportunity to say goodbye.

173 SNB 17003-17312.
174 SNB 469.
175 SNB 440, 2161, 5619, 7179, 80065.

> "When he left, I was on my own".

He said that he had been unable to trace his brother since then. Such a practice no doubt precluded the tensions of a farewell scene, but it must, even in the 1960s, have been apparent that to fracture family relations in this way was poor childcare. HIA 132 was also prevented from visiting his grandmother and aunt when the nuns found out that they were not Roman Catholics, though his aunt wanted to adopt him.[176]

Religion

133 Religious observance played a big part in the boys' lives, but it was not generally a source of complaint. HIA 99 said that there was Mass every morning, and prayers before and after meals, but said he was content with the religious regime.[177] HIA 183 remembered the Mass in the morning, and after tea, Rosary and Benediction.[178] HIA 159 recalled a practical problem:

> "…going to confession always seemed a long-drawn-out affair, waiting for ages to go to the box. In the end it was decided to send just a few boys at a time, as so many wanted to go to the loo that they wet themselves when they got there".[179]

134 When HIA 423 was at Nazareth Lodge she felt privileged when going to chapel as she was provided with a special outfit and the nuns did her hair so that she looked lovely.[180] She was expected to give the impression to other church-goers of being happy.[181]

135 HIA 152, however, was critical:

> "Religion was a very big part of our daily routine with mass, benediction and confession. It was more important to the nuns than education, which is why we were not well educated in Nazareth Lodge. I have no recollection of homework or exams. We went to school in Nazareth Lodge. It felt like we never left the building".[182]

136 HIA 24's mother was a Catholic but his father was a Protestant. As an altar boy he received communion but he had not been baptised, and the nuns became aware of this while Bishop Mageean was visiting. HIA 24 said he

176 SNB 586-587.
177 Day 82, p.78.
178 SNB 523.
179 SNB 32186.
180 SNB 743.
181 Day 87, p.13.
182 SNB 516.

was dragged out of the church by the ear as they were "really angry". He was therefore baptised and confirmed on the same day.[183] Coughing in church was considered the worst crime as it was seen to be disrespectful, according to HIA 33, and SR 118 hit him with the spindle of a chair back when he had a tickly cough.[184]

137 For the Sisters, religious observance was clearly of great importance. In a report on a visitation from 28 October to 5 November 1989, presided over by the Regional Superior, it was recorded:

> "The work is very demanding and time-consuming, still the spiritual life of the Sisters should always be given priority; sufficient staff should ensure that this is so."[185]

In a statutory children's home, the only purpose of the staff team coming together would be to care for the children; in the case of homes run by the Congregation the statement suggests that the spiritual life of the Sisters took precedence, with the care of children and others being the practical outworking of their faith. No doubt the spiritual life of the community strengthened the nuns in their total commitment, but the practical effects of the thinking described above (and elsewhere in the visitation reports)[186] led to the use of charge boys in earlier times and the associated problems described in this chapter.

Records and Care Planning

138 It appears that for many years the records kept about the children in Nazareth Lodge were minimal, BR 2, who admitted boys from Nazareth Lodge to Rubane, said that there were few or no records provided about them. He explained that the information received was sparse in the extreme "without names of parent/siblings, where they came from, their medical history, their educational attainments or special needs".[187] **We consider the Sisters' failure to pass relevant information about a child's time in Nazareth Lodge, even if little was known about their lives before coming into the care of the Sisters of Nazareth, was unacceptable and showed a lack of care and consideration for each child's individuality, development and well-being which we considered amounted to a systemic failing.**

183 SNB 419-420.
184 SNB 139.
185 SNB 19890.
186 SNB 19892.
187 RUB 1040.

139 In the absence of records, any planning of the boys' care can only be inferred. There must, for example, have been some discussion and preparatory work undertaken when boys were selected to go to Australia. Planning the move to Rubane would have been simpler, as boys moved once they were eleven. Arranging summer family placements must also have taken time. However, none of this would have matched the systems established in the 1960s and 1970s in England and Wales whereby childrens' needs were comprehensively assessed and plans for their care were drawn up and reviewed at intervals.

140 In the mid-1970s the cases of children who were in the care of the local authority were reviewed every six months. The reviews were held in the office, involving the social worker and the senior social worker; no staff from the home were present. NL 190 said that, by contrast with the authority's reception and assessment home where the staff were welcoming and worked as partners with social workers, the staff at Nazareth Lodge were not looking for social work involvement, and to fulfil her commitments to the boys she felt that she had to drive the contact.[188]

141 SR 52, who worked in the two Nazareth Houses in Belfast and Derry between 1975 and 1977, said that the Belfast home was ahead of that in Derry in a number of respects. All the children had their own social workers, and they visited every month or two months. There were six-monthly reviews of their cases. The units in Belfast were mixed. Lay staff were appointed earlier in Belfast. Record-keeping was also better. Her view was that the improvements in practice had been accelerated by the involvement of social workers.[189] SR 52's views were corroborated by SR 18 and SR 2, who also worked in both homes.[190]

142 Daily logs commenced in January 1984, possibly initiated by SR 46, who was qualified in social care. According to NL 114 under SR 222 every child had their own diary.[191] At that time, social workers visited monthly, progress reports were made and reviews were held.[192] NL 114 said that, as a houseparent, she reported problems to SR 46, but did not attend or contribute information for reviews.[193] Under SR 148 the keyworker system (which she had learnt about on her qualifying course at Aberdeen) was

188 Day 109, p.75.
189 Day 29, p.83.
190 Day 29, p.83.
191 Day 104, p.75.
192 SNB 62319, 62306, 62300.
193 Day 104, p.75.

introduced. She also gave lay staff access to files and encouraged them to contribute to daily recording.[194]

143 According to SR 46, in the later years social workers visited the children and the children could phone them. SR 46 prepared reports on the children's progress for the social workers, and copies were kept on their files, together with their medical records, details of family visits and so on, in locked filing cabinets in their respective units.[195] It would seem that by this time standards of record-keeping were probably adequate, and that social workers were undertaking the necessary care planning. Good practice would also have entailed involving children in their reviews.

144 In summary, we were critical of the lack of background information the Sisters of Nazareth provided to the De La Salle order about boys transferring from Nazareth Lodge to Rubane and considered it amounted to a systemic failing. However, it appears that, starting from a low baseline, standards improved over the period covered by the evidence we received. For some time the quality of records was poor in relation to professional expectations at that time, but once the sisters were trained, standards were improved to an acceptable level.

Staffing

145 At the start of the period covered by the witnesses' evidence, the groups were of sixty boys, later split into two thirties. At this time a single nun worked with each group. Later, lay staff were appointed, increasing in number until there was a nun and four lay staff per group. In parallel, the group sizes were reduced. These were major improvements, but they need to be set against expectations in residential childcare services at that time. Until the 1980s neither the lay staff nor the sisters were trained in residential social work, and the staff numbers remained inadequate by accepted standards.

146 Sr Brenda said that:

> "The Sisters who were responsible for attending to the children would normally have had some form of early year's childcare qualifications".[196]

The commonest qualification at this time was known as the NNEB (National Nursery Examination Board) and it was designed primarily for 16-18

194 Day 116, p.19.
195 Day 93, p.44.
196 SNB 1502.

year olds who wanted to work in day or residential nurseries with little children. Its academic standards were not on a par, therefore, with other professional qualifications and although there was no higher qualification in that field it was generally viewed as a preliminary award. Its curriculum did not address the needs of older children and young people, and it was inadequate as a preparation for residential childcare.

147 The Castle Priory report, *Residential Task in Childcare*, which was published in 1969, was quickly accepted as standard guidance. The standards which the report proposed reflected the staffing levels already adopted by progressive providers,and were intended as a prompt to encourage improvements among those who had not yet attained those levels.

148 There are variations in the report's recommendations, depending upon factors such as the length of the working week (40 or 45 hours). This makes comparison with the contribution of the Sisters difficult as they lived on site, and were therefore capable of covering the equivalent of two or three staff, though it is arguable whether this was a reasonable expectation. Allowance also has to be made for the support provided by the Mother Superior, the sisters who worked in the laundry, kitchen and workroom, and the gardeners and handymen, though the Castle Priory figures exclude domestic and other ancillary staff.

149 The report's recommendation was that a 30-bedded unit required between 13.5 and 18 staff, as noted in the 1983 SWAG inspection aide memoir.[197] From 1 April 1987 the weekly payments were increased by the Eastern Board from £80 to £147, on the condition that two extra staff were employed in each group.[198] Even when the units had reduced to sixteen children, the staffing complement should have been 10 per unit. The contrast between these standard expectations and the reality of staffing at Nazareth Lodge is stark.

150 There was a sharp dividing line between the sisters and the lay staff. The nuns filled the managerial roles and took the significant decisions. It appears that when they were first appointed the lay staff were resident and were expected to undertake the practical tasks of caring, but over time almost all the lay staff became non-resident, so that the sisters were the only resident staff. As a result, SR 148 observed, the nuns became

197 SNB 50506.
198 SNB 100126.

the children's primary attachment figures.[199] It is significant that even in the 1980s when SR 148 was a qualified social worker, she still ate in the convent, even though the residential workers now ate with the children.[200]

151 Until the latter years, lay staff never did night duty, as the sisters were resident. An unfortunate side effect was that the lay staff had to work split shifts to cover the periods before and after school, and this was unpopular, as the working day could amount to twelve hours, and the period in the middle of the day was not useful as time off.

152 When SR 148 qualified and moved to Nazareth Lodge in 1980 she was the first to hold a social work qualification.[201] Staff were later seconded to Queen's University for the social work qualifying course and to Rupert Stanley for the social care course. By the time the home closed, all the staff were qualified. Following criticism by the Inspectorate about the lack of male role models, SR 148 was the first to employ male staff, in 1985.[202]

153 SR 52 wrote:

> "In 1980 the appointment of [SR 148], who was a qualified social worker, was a progressive and positive step. She took on a monitoring and mentoring role and was a great support to staff in each of the groups. There were serious efforts to improve practice and planning for the children. Documentation and communication was greatly improved and a greater effort to release sisters and staff for professional qualifications in social work became the norm. The issue of staff ratios and qualification was inextricably linked to the question of finance. Each child was assigned a keyworker. Sister had a lot of contacts with the social services and with Mrs Grogan from the Down and Connor office. The latter received half her salary from Nazareth Lodge."[203]

154 Jim Tracey worked as a member of the residential childcare staff at Nazareth Lodge from 1984 to 1992. He wrote:

> "The central figure, however, in most of the children's lives, was the Sister-in-Charge in each of the three units. She lived in the unit 24-7, and most, if not all of the children, often saw her as the 'mother figure'. This arrangement meant that staff (during my time) were not

199 Day 116, p. 51.
200 SNB 80110.
201 SNB 80109.
202 Day 116, p. 67.
203 SNB 1594.

required to work beyond 10 p.m. This changed some years after I left the home and Nazareth Lodge complied with night-time supervision requirements in line with other statutory and voluntary residential children's homes".[204]

155 Jim Tracey trained and obtained the Certificate in Social Services, being promoted to Assistant Team Leader.[205] He could not be promoted further, as all the more senior posts were held by sisters.[206] This glass ceiling for lay staff caused irritation and was divisive.

156 The division in the staff between the sisters and the lay staff was apparent at an inspection in 1983. It was noted that staff meetings were held in only one of the three units. The lay staff had no sitting room or kitchen where they could relax off duty. This was unfortunate as they had at times to work split shifts, an unpopular practice which had been abandoned in most residential childcare services some time earlier. In consequence, while the sisters had the support of their community, the lay staff did not socialise; overall, these divisions must have undermined teamwork within the staff group as a whole.

157 The home had the benefit of volunteers, which augmented the range of relationships for the children and offered them a wider variety of activities. NL 14, for example, had been a resident at Nazareth Lodge, but on leaving he called in regularly to have his tea. He also helped by playing football with the boys and coaching them. Two girls and one boy alleged that he had abused them, which he denied.[207]

Childcare

158 Some witnesses made a variety of observations which had a bearing on the quality of childcare. HIA 141, for example, was highly critical of SR 29, who ran her group. On her first day in school SR 29 marched her down the corridor and told to go in to her classroom. "[She] just left me outside the door. I had no support or help".[208]

159 HIA 141 shared a room with an older girl who was put in charge of her to help with her homework, but the girl smacked her hard and said she was thick and punched her head until HIA 141 cried loudly. Her sisters heard from the next unit and confronted the older girl until the nuns intervened

204 SNB 2200.
205 SNB 2201.
206 SNB 2201.
207 SNB 80099-80100.
208 SNB 109.

"like a riot squad".[209] SR 29 cut her hair, so:

> "you were left that you didn't know if you were a boy or girl. ...I felt that my identity was stripped".[210]

Aged five or six she was made to stand on a tin mop bucket to do the dishes on alternate days. She also recalled being smacked a lot, stating that SR 29 put over her knee and used a leather strap to hit her.[211] This was denied by SR 29, who said:

> "...I never put a child across my knee or used a leather strap".[212]

160 HIA 141 said that her social worker never helped her, as she went straight to SR 29's office and there was never an opportunity to speak to her confidentially.

> "I think [she] was afraid to leave me alone with her in case I said anything. The Sisters and social workers never got down to my level as a child and they were always looking down at me. I always looked at the ground because I was afraid of looking into their eyes because I was so afraid of them".[213]

161 HIA 154 contrasted Nazareth Lodge with the children's home to which he and his siblings moved:

> "I was so happy to move...; it was like a holiday camp. ...It was smaller than Nazareth Lodge. ...We got better clothes, pocket money and better food. We could go to the fridge whenever we wanted and we got three meals a day. We were very well looked after."[214]

Nor was he sexually abused, as he had been at Nazareth Lodge.

162 With better resources and the introduction of up-to-date thinking, standards of childcare at Nazareth House could have been improved significantly. The children could have had better clothes and food, better bathing arrangements and better schooling. The unnecessary chores could have been stopped. There would have been no need to put class boys in charge. Staff could have been better trained. Most importantly, the children could have had individual attention and care from staff, ranging from the symbolic celebration of their birthdays to care planning involving

209 SNB 111.
210 SNB 110.
211 SNB 110.
212 SNB 1927.
213 SNB 110.
214 SNB 885.

social workers and preparation for discharge.

163 Even when staffing levels had been improved they fell short of Castle Priory expectations. The staff were simply too few to give sufficient individual attention. Understandably some children were seen by sisters as favourites and others obtained attention by misbehaviour, but many would have passed through Nazareth Lodge by keeping their heads down and avoiding attention. It is significant, though, that when improvements in staffing and living conditions had been made, the volume of allegations dropped dramatically, and the quality of care was clearly better. Jim Tracey, for example, recounted the ways in the later years the staff tried to create something of a family atmosphere, by staff and children cooking meals together, and sharing in the laundry and other chores. Although there was a central kitchen, over time the staff in the units requested budgets and prepared their own meals.[215] This was evidence of good practice.

164 In the preceding paragraphs, twenty-three aspects of daily life have been considered. In four of these (the management of bathing and bedwetting, the use of Jeyes fluid and force-feeding) we have concluded that the specific practices amounted to systemic abuse. Some aspects were positive, such as the summer family placement scheme and the holidays. **For the most part, until improvements in physical conditions, staffing levels, staff training and professional practice were introduced, the evidence indicated poor, out of date childcare practice, and we consider this was systemic abuse.**

165 It is against this general background of poor quality care that the allegations of physical, emotional and sexual abuse have to be considered.

Allegations of Abuse

Physical Abuse by Staff

166 A number of witnesses spoke of a general atmosphere of violence, and of physical abuse by several named sisters. The evidence below indicates the extent of the abuse from the 1940s to the mid-1970s, when the allegations diminished in frequency. In most cases a relatively small number of allegations were made against any single individual, and though some were serious, they were made by only one witness in almost every case.

167 There were, however, four members of staff against whom we have

215 SNB 2200.

received multiple allegations of physical abuse. Two were sisters, SR 118 and SR 34, and two were lay staff, NL4 and NL 5. Between them, the four key names were the subject of perhaps 90% of the witnesses' allegations, and they are dealt with individually.

168 HIA 307 was at Nazareth Lodge in the late 1940s and 1950s, and he found the regime "bleak, harsh and cruel". He said that the nuns:

> "...were at best indifferent but more often were sadistic bullies who spoke with harsh loud voices in scornful, dismissive tones. They were quick to strike out and provided no reassurance or comfort to a small frightened child."[216]

169 HIA 192 was at Nazareth Lodge in the late 1940s and early 1950s. He said he was accused of biting a notebook and when he refused to own up, SR 101:

> "...beat me in front of the entire class. She said she was going to beat me until I told the truth. She made me kneel down in front of the class with my hands out. She hit me with the handle of a hurley stick. She kept hitting me until she got tired. My arms dropped down from the tiredness of holding them up and my fingers curled from the pain, I lost five fingernails in the next couple of weeks as a result of the beating".[217]

In oral evidence he said that he counted 66 strikes before he lost count.

> "I was fighting a battle in my mind. I can't say I done that, because I hadn't done it. So it became just me and her sort of thing. Actually I didn't feel the physical pain because it was so - so much thinking I'm going to win this. I'm going to win this".[218]

170 HIA 210's main criticisms were levelled at SR 62. Attending school was "a terrible time for me" as SR 62 beat him hard if he was thrown out of class or got his homework wrong.[219]

> "She used to beat me with brush shafts, metal parts of the hoover and large wooden tweezers you used for washing...This happened once or twice a week and I was often bruised".

He said that he was known as SR 62's pet and other boys were jealous,

216 SNB 097.
217 SNB 300.
218 Day 92, pp.26 to 28.
219 SNB 599.

but it was terrible; no one would want to be her pet.[220]

171 HIA 89 said that when he was aged six or seven, nuns started to beat him, for example for failing to clean the floor to their satisfaction. He said he was hit on the palms of his hands and on his backside, with sticks, straps and hurley sticks and that SR 118 and SR 100 beat him the most. He said that nuns put the boys' hands in cold water before hitting them with a stick, so that it would intensify the pain.[221] HIA 89 said that he also had to stand naked and then be beaten.[222]

172 SR 149 looked after the chapel and HIA 89 said that she beat him with a whip. He said that she also hit him with a crutch for being late and the boiling water he was carrying scalded him, such that he spent two or three weeks in the Mater Hospital. He told us that on another occasion she threw him down the stairs and broke his arm. The Congregation said that there were no corroborative records concerning these incidents, though they doubted whether the incidents would have been as described.[223]

173 SR 47 was said by HIA 422 to have hit him regularly with a big stick "half an inch thick".[224] HIA 87 said he was involved in an incident when he was accused of killing some pet mice; he was beaten and lost his temper, eventually being caned severely and shut in an upstairs room for two weeks, as he said he was going to run away. He told us he was also shadowed for the following two weeks.[225]

174 HIA 427 spoke of regular physical assaults:

> "If you did not greet a nun properly you got a slap on the face, your hair pulled or you would be lifted up by the ears.[226] …the nuns kicked and beat us, cut and shaved our hair, and used Jeyes fluid to clean us."[227]

The boys were not allowed to leave the grounds, and HIA 427 added:

> "If you sneaked out the nuns would give you a serious beating."[228]

175 HIA 307 alleged that nuns boxed him on the ears and in 1956 his hearing

220 SNB 598-599.
221 Day 83, pp.14 to 15.
222 Day 83, pp.14 to 15.
223 SNB 488, 1932, Day 83, pp.10 and 12.
224 SNB 212.
225 Day 83, pp.40 to 42, SNB 258-259.
226 SNB 562.
227 SNB 563.
228 SNB 563.

was impaired. The pain was excruciating and made him nauseous. He said that his hearing difficulties had affected communication and employment prospects throughout his entire life. He said:

> "One of the most painful punishments dished out by the nuns was the beating of my fingertips with a wooden ruler. The nuns would grab my hand and squeeze the fingers all bunched up together until they went red and then strike them across the fingertips with a ruler. The pain was terrible and it was done with viciousness especially in winter when our hands were so cold, so they could inflict the greatest pain and generate fear".[229]

176 Some witnesses had mixed feelings about the sisters. HIA 41, for example, was deeply attached to SR 30, but he also alleged that she slapped him and humiliated him.[230] He said that she had a vicious temper[231] but she was "80% fantastic" and he had discussions with her about religion.[232] She also spoiled him by giving him money, budgies, canaries, mice and goldfish.[233] His evidence suggests that HIA 41 was an example of a boy who benefited from the individual attention he was given, which might have been seen by other children as favouritism.

177 A number of witnesses reported that while the sisters were caring, it was the civilian staff who abused them. When the sisters went for their evening prayers and time together as a community, the civilian staff were left in charge, and many of the allegations of physical abuse related to this part of the day. HIA 375 was highly critical of NL 155, a lay worker in her group, describing her as:

> "an animal who should never have been allowed to work with children. We were petrified of her".[234]

178 HIA 48 also said that she was chased and hit by NL 14 and NL 122, two of the gardener/ handymen.[235] DL 40 said that NL 122, one of the handymen was a nasty bully and hit him several times, such that he was terrified of him, but as NL 122 had caught him out of bounds he did not complain about NL 122's behaviour.[236] NL 122 denied the assaults, saying that he

229 SNB 098.
230 SNB 440.
231 SNB 443.
232 Day 89, p.152.
233 SNB 446.
234 SNB 732.
235 SNB 861.
236 SNB 1873.

never abused, punished or chastised any child, and that he assumed the witnesses had been mistaken in identifying him.[237]

179 The physical abuse also continued in the schoolroom. Since the schoolroom was on the premises, and some of the sisters acted as both care staff and teachers, the schooling day would probably have been seen by the boys as a continuation of their life in the home. This contrasted with the experience of children who were being abused in their own homes or in children's homes but who sometimes found attendance at day school offered a welcome relief.

180 HIA 204 said that a lay teacher, NL 118, hit him across the face with a whip and left a "terrible mark"; he was told to lie to the nuns about it.[238] On the other hand, HIA 225 considered the use of the cane in the school justified, for example when a teacher NL 63 gave him six of the best for copying a wrong answer,[239] but he considered the nuns' ways of disciplining the boys to be cruel – pulling their hair, grabbing their cheeks and pulling their sidelocks.[240]

181 HIA 132 also said that NL 63 was "fond of the strap" and pulled boys up by the hair if they did something wrong.[241] NL 63 said that he had expected to be able to teach without using corporal punishment, but had found that he needed to use the strap as it was effective in maintaining control so that he could get on with teaching. He was not required to inform the Principal when he used corporal punishment.[242] Generally he was seen as strict but fair.

182 HIA 10 said she considered SR 46 the worst nun, because she nipped her and shouted at her in Mass, and used bamboo canes and "a ruler strap, a brown leather ruler with white stitching which she hit us with".[243] HIA 10 further said that SR 46 scrubbed HIA 10's skin with a scrubbing brush till it was red and bleeding, and hit her with a spatula till her sister intervened.[244]

SR 118

237 SNB 80093.
238 SNB 305.
239 SNB 534.
240 Day 87, p.40.
241 SNB 585.
242 Day 110, p. 20.
243 SNB 749.
244 Day 104, p. 25.

183 SR 118 was born in 1900, joined the Order in 1919, and was at Nazareth Lodge first in 1922, then for 25 years from 1929 to 1954 when she left to move to Aberdeen, where she died in 1974.[245]

184 SR 118 was seen as "very much in charge", and "the most punitive". HIA 183 said he saw SR 118 wipe HIA 427's soiled pants "violently and cruelly" in his face.[246] We have already noted SR 118's unacceptable treatment of enuresis.

185 In his account to the police, HIA 33 referred to beatings by SR 118:

> "I had to kneel in front of [SR 118] and put both hands out and she used the rung of a chair to beat and slap us until our hands bled. This happened every morning during my stay and to other children as well and we all had witness to this. This was her idea of keeping control".[247]

186 HIA 192 told us of physical abuse by SR 118. He said that she hit him on the legs with a hurley stick to get him up in the morning. (The Order did not accept that a hurley stick would be used).[248] He said that SR 118 beat all the boys in the dormitory when the radiator leaked. She beat HIA 192 when he knocked a light with a crozier as altar boy during the Bishop's visit. As a charge boy he was beaten if one of the boys for whom he was accountable misbehaved, lost clothes or wet the bed.[249] He concluded: "She destroyed my confidence".[250]

187 According to HIA 99, SR 100 never inflicted punishment but supported SR 118 when she punished children. On the other hand HIA 427 said that SR 100 was also very cruel, hitting him on the knuckles or across the legs, with a black strap, sticks or possibly a cane.

188 HIA 89 said that SR 118 and SR 100 beat him the most. Things went wrong for HIA 89 on moving from nursery to young boys' unit.[251]

> "[SR 118] would shout or beat us even though we weren't doing anything wrong. If work wasn't done right, God help you. You would get battered on the floor. [SR 118] would usually use a hurley stick, an

245 SNB 1904, Day 82, p.33.
246 SNB 522.
247 SNB 1641.
248 SNB 1599.
249 SNB 300-301.
250 SNB 300.
251 Day 83, p.9.

ordinary stick or strap to beat us. [SR 118] was a wicked old woman".[252]

189 HIA 204's report on SR 118's treatment of bedwetters in the 1930s has been quoted above, and HIA 408 said it involved hitting boys with a strap as they lay naked on the ground, and, if they turned over, putting her foot on their groin.[253] He added:

"[SR 118] was only happy when she was beating you".[254]

190 HIA 99 said that SR 31 was:

"a motherly figure to the boys" and "gave me the only comfort in that place. Whenever she was there I felt protected, and she showed us affection".[255]

Unfortunately SR 186 was often away unwell, and when she was absent SR 118 was in charge, and:

"A gloom came over the whole place".[256]

191 HIA 87 said that SR 118 could be pleasant, but "The job was sometimes too much for her". If she was in a bad mood she got rid of her ill-feelings on the boys.[257]

192 The Order acknowledged that SR 118 might have slapped children as a punishment and on occasions she might have lost her temper, but they "refuted" all the more serious allegations and denied that she would have had a hurley stick.[258] While allowing for some possible exaggeration, on balance we found the witnesses' evidence persuasive.

SR 34

193 SR 34 entered the Congregation in 1929 and died in 1997. She worked at Nazareth Lodge from 1952 to 1973. In 1960 she became Principal of the school, and remained in this role until the two schools of Nazareth Lodge and Nazareth House were amalgamated.[259] As the Principal, SR 34 may have felt that standards of discipline were her responsibility, and she may have acted more firmly than she otherwise would have done in order to assert her control. While she was severely criticised by several witnesses,

252 SNB 487.
253 SNB 220, Day 82, p.37.
254 Day 82, p.38.
255 SNB 278.
256 Day 82, p.82.
257 Day 83, pp.32 to 34.
258 SNB 1904-1905.
259 SNB 1900.

SR 34 clearly had positive qualities.

194 HIA 104 said that when SR 34 put him in charge of the tuck shop he let her down by stealing sweets and then denying the theft twice, until she made him empty the sweets out of his pockets.

> "She gave me a really bad beating that day because I had let her down. I ended up crawling under the table and she was grabbing me out from underneath the table. She lost it completely and she was kicking me with her feet and boots and hitting me with her hands. I was about seven or eight at the time and I felt really bad about the incident."[260]

In oral evidence he added:

> "This is the only bad thing I remember SR 34 doing, because overall I adored her, but I think on this occasion she was in a blind rage because of what I had done."[261]

195 HIA 183 said that SR 34 made all the boys kneel in the corridor for an hour, when it was very cold. She realised she had been unfair and gave them all a chocolate; this was an unusual event.[262]

196 Other witnesses were more critical. HIA 64 wrote:

> "[SR 34] was in charge of St Joseph's group and she was a bad one. She was the worst nun. If you did something wrong, she would take you by your sideburns, lift you up off the floor, drop you and then kick you. She was a big, hefty woman. She weighed about sixteen stone, and we were only six or seven years old".[263]

197 HIA 110 described SR 34 as "really bad", having hit him on many occasions with a stick, a strap or a hand. On one open day he was given threepence or sixpence by a visiting nun, and:

> "The next day SR 34 got me by the cheeks with her big nails and lifted me clean off the floor by the cheeks",

leaving marks on his face.[264] He explained to police that SR 34 gripped his cheeks "with the heels of her palms near my jaws and her fingertips near to my eyes".[265]

260 SNB 493.
261 Day 85, p.72.
262 SNB 522, Day 84, pp.53 to 55.
263 SNB 479.
264 SNB 501.
265 SNB 60911.

198 HIA 422 said that SR 34 used to pick up boys by the sidelocks and swing them round; she also whipped boys round the legs with a cane.[266] HIA 19 described SR 34 as "very wicked", as she lifted him by the cheeks or the ears and threw him against the wall or on the floor in the classroom. On one occasion she thought he was reading a comic, and she pulled HIA 19 off a bench, trailed him down the passage and kicked him in the face, leaving him black and blue, only to find that he had been reading a Missal.[267] According to HIA 132 SR 34 was "a very angry person", and she hit him with sticks. She also taught him in school, smacking him in the face when his sums were wrong, and pulling him up by his sideburns or cheeks. He was also shouted down by her for showing off if he tried to answer a second question.[268]

199 When he suffered athlete's foot badly, HIA 225 cried and was beaten by SR 34 with a bat for crying.[269] HIA 427 told us that SR 34

> "would have insisted my trousers were taken down when I was being strapped for wetting the bed. After she threw the wet and dirty sheets over me I was subjected to cold baths".[270]

HIA 247 was beaten by SR 34 for running away and did not try it again.[271] He said that the nuns used their waist straps, or cinctures, to beat boys and they hit them anywhere.[272]

200 HIA 152 considered SR 34 to be an evil bully:

> "She used any excuse to beat me. If you did anything wrong, no matter how trivial, she would give you a time to be in the dining room. You had to line up and had to wait your turn to be hit. She would hit us with a strap".[273]

If the charge boys were disobeyed, they told the younger ones to go to see SR 34.

201 HIA 307 summarised:

> "[SR 34] was the most terrifying nun at Nazareth Lodge. She was an aggressive bully and she was the biggest nun. She was always yelling

266 SNB 214.
267 SNB 407-408.
268 SNB 585.
269 SNB 531.
270 SNB 563.
271 SNB 605-606.
272 Day 84, p.119.
273 SNB 515.

at the children and punching us with closed fists. She also boxed our ears. She had a nasty, angry face and seeing her coming up the corridor made you shrink back against the wall to try and not be noticed."[274]

202 In a considered view of her contribution, DL 40 said that SR 34 had the wrong temperament for the work. She worked 24/7, which he considered unfair, and when she calmed down, she was a lovely person.[275] This witness was very appreciative of what the Sisters had done for him, and his comment can therefore be taken to imply that SR 34 frequently lost her temper.

203 The Congregation accepted the accounts of SR 34's abuse offered by the witnesses, but pointed out that SR 34 was "held in very high esteem by many of the former children", which was evident in the great number who attended her funeral, and emphasised her "warm compassion for vulnerable people".[276]

NL 4

204 NL 4 considered becoming a nun, like her sister, and twice she commenced her novitiate, but it did not work out. In the course of her career NL 4 worked in various care jobs, including several spells at Nazareth Lodge amounting to between seven and nine years in total.[277] She received board and lodging and "a very small wage" of 10 shillings per week at first, and £2 later on from the Sisters. She stayed overnight in staff accommodation in the attic where the staff part was curtained off from the children's, and later she lived in staff quarters.[278]

205 NL 4 worked to the instructions of the nuns. There were no staff meetings in which she could have contributed or learnt from colleagues. She was given no specific instructions on the appropriate use of physical chastisement. She played no role in the oversight of the children's care, for example through participation in reviews, communicating with social workers, or having access to the children's case files.[279] NL 4's roles were essentially practical: getting the children up, overseeing their chores, supervising mealtimes and helping in the laundry, kitchen and parlour.[280] She said

274 SNB 098.
275 Day 95, p.66.
276 SNB 1901.
277 SNB 80006.
278 Day 113, p.10.
279 SNB 80007.
280 SNB 80008.

that on occasion, when the nuns were out collecting, she had to supervise 80 to 100 children on her own on trips to the Curzon Cinema in Ormeau Road. She was relieved that nothing untoward occurred.[281]

206 She worked very long hours, eating lunch while the children were in school and covering the evening period when the sisters were in chapel. She and NL 5 were the only lay staff not to go home at weekends. On Thursdays she had the day off and was taken home by the handyman, returning by bus.[282] There were no set hours for residential childcare workers at this time, and when the first lay staff were appointed the Sisters seem to have expected the same dedication to the care of the children that they required of themselves.

207 According to HIA 36 NL 4 was seen as the member of staff who could deal with children who were getting out of hand.[283] If so, other staff presumably came to rely on her, and in a large children's home with a proportion of children who may be disturbed and displaying difficult behaviour, the support of such a person may be valued by colleagues. However, the fact that staff needed to maintain control does not excuse physically abusive treatment of the children.

208 NL 4 was "the worst member of staff" according to HIA 110. When he wet the bed she threatened to put him in the washing machine. When cleaning was not undertaken to her satisfaction she slapped the boys' faces and legs. HIA 110 said that he feared NL 4, who never showed any love or affection.[284] HIA 19 said that both NL 4 and NL 5 separately:

> "used to take us into the laundry and they would lift us and put us in the machine, and close the lids for a few minutes and say they were going to turn it on. They obviously never did, but it left you in fear and squealing, yelling and crying. It gave us nightmares."[285]

209 HIA 56 said that he saw NL 4 rub NL 174's face in the excrement when he soiled his bed one night, to make an example of him.[286] He said:

> "Everyone was afraid of her and they cheered in the refectory when they saw her leave with her bags. However she returned about six months later dressed as a nun."[287]

281 SNB 80008.
282 Day 113, p.37.
283 Day 86, pp.43 to 46.
284 SNB 501-502.
285 SNB 408-409.
286 SNB 466-467.
287 SNB 467.

210 HIA 225 at first thought NL 4 nice, as she gave the boys sweets, but his opinion changed when he observed an incident in which DL 157 wet the bed; NL 4 shoved a flannel in his mouth and severely beat him in front of everyone in the dormitory.[288] HIA 225 said that DL 157 had a bloody nose and a split lip, and the boys were told to say that he had been fighting. NL 4 denied beating him.[289] HIA 225 said that NL 4 punched him on the head and the back, but that his father, who worked as a decorator at the home at that time knocked her over, and she left HIA 225 alone for a while.[290]

211 HIA 183 said that NL 4 "was not suitable for that job because of her vile temper".[291] In an altercation she slapped him, he responded verbally and in consequence was denied a weekend trip which had been planned for three months.[292]

212 HIA 225 described how, when the boys were on holiday at Ballyhornan, they took lemonade bottles from the yard behind a shop to get the money back on them; when she found out, NL 4 "went mad" and later that night she hit the culprits with a small wooden bat as they lay in bed.[293] HIA 147 said that both NL 4 and NL 5 used a PVC bat to hit boys on the thighs for absolutely nothing, and that they also used a stick, which they hid from the nuns. The two lay staff abused the boys while the nuns were absent, praying in the chapel.[294] HIA 16 said that NL 4 used a rubber bat to hit him all over. As a result he had "plenty of bruises", but they were untreated as they were not open wounds.[295] NL 4 denied possessing a rubber bat and using it in the manner described.[296]

213 HIA 48 wrote:

> "[NL 4] was the civilian member of staff in charge of our group. She was left in charge of us whenever the nuns were at prayers or in care meetings. She was a wicked one. I used to wet the bed sometimes and she would grab your face and rub your nose in the soiled sheets. She

288 SNB 532.
289 Day 87, p.42.
290 SNB 532.
291 SNB 522.
292 Day 84, pp.55 to 57.
293 SNB 532-533.
294 SNB 32085, Day 87, p.76.
295 SNB 397.
296 SNB 80009.

> would beat me as well with her hands or with whatever object she had to hand. She took a stick to my hands. You didn't have to do anything wrong to be beaten by [NL 4] ".[297]

HIA 48 said that whenever her mother, brothers or social worker visited, a nun or NL 4 sat in, so she did not tell them about abuse.

> "I didn't tell anyone about the abuse anyway because in those days nobody would have believed you. I just kept it all in. You daren't talk about it and even if you did, no one would believe you".[298]

214 HIA 21 was highly critical of NL 4:

> "From the age of six years old I suffered systematic physical and psychological abuse by lay staff member [NL 4]. These abuses continued for the next five years. I lived in total fear of her; she dominated my existence."[299]

He alleged that she punched and kicked him, force-fed him, and degraded and humiliated him in front of other children:

> "In most cases stew was the main diet, which I had a huge dislike for. I used to hide the stew in my trouser pockets and [NL 4] spotted the stain on my trousers and she asked me what I was doing. I told her I didn't like stew. Her response was to take the stew from my pockets and got me in to the middle of the dining room where she held me down on my knees and pulled my hair so that my mouth opened and she forced the food into my mouth. I was crying and terrified as the food went down my throat. She kicked and punched me and hence I swallowed the food. All the children in the room would have witness this. There were no sisters present during this episode as was the same on many other occasions she abused children. The impact of force-feeding [is that I] would limit my intake, that I became fussy about food ever since".[300]

215 He also said that when on holiday NL 4 stamped on his toe, such that he required hospital treatment.[301] On one occasion he attempted suicide "to end the nightmare".[302] He saw her as cunning and opportunist, abusing boys while the nuns were attending church. On his last day he said to

297 SNB 861.
298 SNB 862.
299 SNB 631.
300 SNB 631-632.
301 SNB 632-633.
302 SNB 633.

her, "Thank God we are escaping from you", whereupon she kicked and punched him.[303]

216 In responding to the allegations NL 4 said:

> "I also received no guidance or instructions in relation to the discipline of children. When a child was unruly or misbehaved, I would have sometimes slapped them with my open hand. Normally I would have slapped them on their hands or legs. On occasion I may have slapped them on their bottom. This was a spontaneous thing. I did not use excessive force or cause any bruises or marks on a child's body. I also used a ruler from time to time to slap a child, but this would normally have been one or two slaps, and again I never used excessive force."[304]

217 NL 4 admitted shouting at children, but only smacked them, for example for climbing on windowsills. She felt she had to be strict, "making sure they didn't get into any harm or mischief".[305] Despite these general admissions, in responding to the evidence put forward by witnesses, she said that most of the specific allegations were untrue. She denied striking any child.[306] She also felt that in the course of giving evidence some witnesses had exaggerated or fabricated allegations to put her in the worst possible light.

218 NL 4 concluded:

> "I generally have happy memories of my time working with children in Nazareth Lodge. The conditions were far from ideal, resources were limited and I had to work long hours for little remuneration, but I saw it more as a vocation than simple employment. As I said to one of the former residents whom I met, they were hard times for everyone and in particular the children. I am disappointed that a number of former residents have made these allegations against me but I do not believe I used excessive force or was unnecessarily cruel to the children that I helped to supervise."[307]

219 NL 4 accepted that on occasion she spontaneously slapped children, which supported the persuasive accounts we received of her applying informal physical punishments.

303 SNB 635.
304 SNB 80007.
305 Day 113, p.52.
306 Day 84, p.60.
307 SNB 80018.

NL 5

220 NL 5 was 88 when she gave evidence. She never married, but after working for some time at Foxes Lodge and a nursery, she joined Nazareth Lodge in 1956 and stayed till the home finally closed in 1999. She said that her work was her whole life. SR 52 knew NL 5, and said she was good at settling in new children, "a gentle efficient lady who was generous with her time".[308]

221 NL 5 was clear about her intention to bring up children properly:

> "...we all worked hard to raise the children to have good morals and manners, and I was strict about that - without ever feeling it necessary to hit a child".[309]

NL 5 was responsible for her own group for some time, and she was very particular about the way the group was run. Her group were called the 'Dainties' as they were always well dressed and well behaved. She said she taught them manners and kept them clean.[310]

> "I have fond and cherished memories of my life at Nazareth [Lodge] and many happy children went through our hands and have become responsible and decent adults".[311]

Her group was also labelled the 'Whippets', a name given to them by DL 40 who made up the rhyme:

> "7 little whippets, great and small, and [NL 5] owned them all".[312]

222 NL 5 worked from 6am to 10pm every day, sometimes staying until 11pm to lock up after a meeting, and she was resident in the attic at Nazareth Lodge. She worked closely with the sisters; when not working with her group she acted as receptionist, looking after visiting priests, or she made tea for the sisters. She said that the sisters relied on her.[313]

223 Witnesses from her group said that "after a little bit of television" they were sent to bed earlier than the other groups while the sun was still shining, and that NL 5 was very strict.[314] She acknowledged that she was strict, and saw herself as a perfectionist, demanding high standards.[315] She was

308 SNB 1592.
309 SNB 80033.
310 SNB 80040.
311 SNB 80043.
312 SNB 80039.
313 Day 114, pp.70 and 71.
314 SNB 542 and SNB 585.
315 SNB 100009.

conscientious and controlling in her approach to childcare, keeping the children's clothes in a central cupboard, for example, rather than in their individual wardrobes, and making their beds for them while they were in school. HIA 259 said that the group lived in an old oratory which had a lovely sitting room with a lot of toys, but it was all show, and they only had access to the toys at the weekend.[316]

224 The complaints about NL 5's treatment of children may relate to her earlier years in the home, as, according to SR 52, she moved to become a nursery assistant after her group was disbanded.[317]

225 HIA 110 said that NL 5 was not as bad as NL 4, but she hit his knuckles or the back of his hand with the side of a wooden ruler if he made a mistake.[318] HIA 64 only came across her when she was supervising two groups, and he found her all right at times and at times a "terror" as she "thought nothing of thumping you".[319] HIA 19 said she hit boys on the knuckles with the edge of a ruler, and was not nice to children.[320]

226 When HIA 259 had a bad chest infection she would hit him a smack on the head for keeping her awake with his coughing. He also said that she had a nasty temper, having once stuck a fork in his arm when he did not know how to lay a table.[321] If things were not done to her satisfaction she:

> "...would fly into a rage and punch you with her fists".[322]

227 HIA 104 said that NL 5 slapped him and kicked him severely for playing football when he should have been serving as an altar boy.[323]

228 Other witnesses were not critical of NL 5's care. HIA 36, for example, said:

> "She ruled with a firm hand but she did not cause me any harm."[324]

HIA 21 considered NL 5 strict, as she slapped him across the face and lifted him off the ground by his sideburns,[325] but he thought she had been under NL 4's influence[326] which NL 4 denied.[327]

316 SNB 542.
317 Day 112, pp.143 and 144.
318 SNB 502, 60915.
319 SNB 479.
320 SNB 407.
321 SNB 543.
322 SNB 544.
323 SNB 493.
324 SNB 427.
325 SNB 636.
326 Day 84, p.107.
327 SNB 80031.

229 HIA 397 said that NL 5 was strict but not cruel; she acted like a mother figure, and he was positive about the way that she had helped to arrange foster care and adoption for him.[328] He contrasted her with NL 19, who had a "rough and abrupt manner" and who stuck her stiletto heel on his hand.[329] HIA 132 said that NL 5 physically abused him. She inspected boys' underpants regularly and beat boys if they were not clean.[330]

230 All in all, nineteen witnesses mentioned NL 5 in their evidence, consisting of sixteen who approached the Inquiry and fifteen who gave evidence to the police, with twelve speaking to both the police and the Inquiry.

231 NL 5 said:

> "I just feel that I have been stabbed in the back after all my hard work all my life. I thought I did a good job but I didn't realise these things would come up. I can't understand it and I never will".[331]

Despite ups and downs, she had a happy time there.

> "I was very happy in Nazareth Lodge and…I wouldn't have spent forty years in it if I wasn't happy…"[332] I thought I gave my life for them and I left Nazareth Lodge that day we locked the front door, and I thought 'Well, you've done a good [job].' I said to the sisters, 'Now we have nothing to worry about. We gave all we could to the children and we looked after them and we brought them up morally. We taught them manners and we thought we did a good job. We didn't think things were going to be said about us like that because those things never, never happened.'[333] I feel sick that I devoted my life to raising these boys in their time of need only many decades later to be accused of being someone I am not. I worked long hours on little or no salary to help raise many dozens of boys to be decent young men and I was proud of my role in doing that."[334]

232 In both written and oral evidence NL 5 was firm in denying that she had ever hit any boys:

> "I should state at the outset that I never smacked or assaulted any child in my care. I deny all these allegations…"[335]

328 SNB 226,229.
329 SNB 226.
330 SNB 585.
331 Day 114, p.169.
332 Day 114, p.171.
333 Day 114, pp.171 and 172.
334 SNB 80092.
335 SNB 80031, 80067.

She had warm memories of her work and recalled the round of applause she had received at a reunion of former Nazareth Lodge boys.[336] It is our view that NL 5 did indeed care for the boys for whom she was responsible and she worked conscientiously for them to make sure that her group had the best conditions. It is also our view that the witnesses' allegations are correct, that she was strict, that she lost self-control on occasion, and that she had presumably simply wiped out the memories of the physical punishments she had meted out.

Staff Awareness of Abuse

233 Several witnesses have stated that other sisters were present when they were being beaten. SR 208, on the other hand, worked closely with SR 34 for a year, but said she witnessed no beatings:

> "[SR 34] was headmistress of the School and could exercise control without any effort".[337]

It is, however, hard to imagine that the abuse by SR 118 and SR 34 was unknown to the other sisters working at Nazareth Lodge at the time.

234 DL 269 thought that the nuns would have been unaware of the physical abuse perpetrated by NL 4 and NL 5, and this would be consistent with the observations that they hit boys in the absence of the sisters, when they were in church or spending time in their community.[338] While we accept that the scale of the physical abuse inflicted by the two lay staff was possibly not known to the sisters, it is highly likely that the sisters would have had some awareness of the abuse by the lay staff, either through observing bruising, through any complaints which children made or from comments in casual conversation.

235 A number of witnesses had nothing critical to say about the sisters and expressed their appreciation of their dedication to caring for the children. HIA 56 for example said:

> "The nuns were good and I have nothing bad to say about them. I was happy with them. They made sacrifices for us. I just suppose they didn't see what was going on. Even today I really miss them."[339]

336 SNB 80034.
337 SNB 1863.
338 SNB 80071.
339 SNB 467.

236 On behalf of the Congregation, Sr Brenda McCall said:

> "One of the main elements which has to be accepted is that the Sisters' general policy of no physical punishment of children was not implemented. There are instances where children were the subject of a physical assault and this is not acceptable when the care of children is to be considered".[340]

When asked whether nuns were breaching their vow of obedience in failing to follow the Order's policy, she explained that the vow related to spiritual matters, not professional practice, and that the policy was understood but not written down. Sr Brenda acknowledged the Sisters' shortcomings:

> "Nuns are only human beings, you know. We are not plaster saints".[341]

In relation to SR 143's investigations, she said:

> "We are a family and maybe she was trying to protect sister [SR 62]".[342]

Sr Brenda expressed the contrition of the Congregation:

> "Not only do we offer an apology now at this stage, I think we need to turn to these people who we have hurt and…humbly ask their forgiveness for our trespasses".[343]

237 Sisters and lay staff who became aware of the physical abuse being inflicted by their colleagues may have felt unable to take action for a number of reasons. They may have seen the physical assaults as no different from the beatings which some parents and some teachers administered. At the most basic level, some staff may have relied upon their more forceful colleagues to maintain order, and may have been thankful that they were prepared to take firm action. If so, these staff would not have wanted to challenge the status quo. Again, they may not have believed complainants. A more complex issue is that the Order was hierarchical, and if the person meting out the punishment were more senior by length of service or role, more junior sisters and lay staff may not have felt able to criticise and challenge; this was not done. Whatever the reasons, the key staff who physically abused the boys were all in post for many years, and they would have contributed substantially to the general atmosphere of the home, apparently unchallenged by their colleagues.

340 SNB 1503.
341 Day 119, p.82.
342 Day 119, p.39.
343 Day 119, p.74.

238 We appreciate that the work was difficult and demanding, and the sisters and lay staff whom we have criticised will have been expected to work long hours with very little time off. They will therefore have been subject to stress, which may have contributed to loss of self-control. However, there were sisters and lay staff who did not resort to physical abuse in order to maintain control. **The physical abuse by staff, particularly on the part of SR 118, SR 34, NL 4 and NL 5, was so extensive that it created a punitive atmosphere. It was contrary to good childcare practice, the policy of the Order and the statutory Regulations under which the home worked. Furthermore the Sisters failed to apply a system of staff selection, supervision and management to prevent or limit the abuse. This was a case of systemic abuse and systemic failure.**

Emotional Abuse

239 The atmosphere of fear generated by the punitive actions of the staff was emotionally abusive. At a time when the boys were meant to be enjoying care and stability in place of their earlier unhappy life experiences at home, to live in perpetual apprehension would have risked causing further damage and preventing them from growing up into confident young people who could make the most of their education.

240 In the earlier decades in particular, the very low ratio of staff to boys meant that few could be given adequate personal attention. The sisters did develop caring and constructive relationships with some boys, but others appear to have survived by keeping their heads down to avoid trouble. The lack of individual attention they received as children may well have affected some witnesses' ability to relate closely during their adult lives.

241 There were also some specific examples of emotional abuse. HIA 307, for example, found the name-calling by the nuns "terrifying":

> "We were all called 'sons of whores', a term I never understood except that it was obviously bad and meant we were all very bad children".[344]

Name-calling was also criticised by HIA 152, as SR 34 called him "button mouth" or "pudding face". The sisters also upset him by their rudeness and the comments they made about his grandparents being poor; they brought him fruit but it was taken off him and he thought it was thrown away.[345] His brother, HIA 19 said that NL 5 labelled them "Darby and

344 SNB 097.
345 SNB 515.

Joan". HIA 16 said that both NL 4 and NL 5 called him names, such as "buck teeth" and "rabbit teeth", and they encouraged the other boys to call him names too.[346]

242 HIA 183 said that one day he was unwell and was told to go to bed. No one checked on him or brought him food and he had nothing to eat. HIA 307 said that he was left alone in isolation when he was ill, and that nobody spoke to him for days.

> "I felt profound despair, fear and loneliness".[347]

As mentioned above, the sisters also prevented his former foster mother from visiting and HIA 307 felt that this had had a serious emotional impact on him.[348]

243 HIA 247 saw NL 64, his brother, beaten for bedwetting. Seeing him beaten for something his brother could not control was the worst thing which HIA 247 experienced while he was at Nazareth Lodge.[349] His brother was later fostered by NL 285, and his foster mother said that NL 64 used to wake up, pleading for someone to stop hitting him.[350]

244 HIA 423 said:

> "There was a lot of physical and mental abuse. The nuns told us that we would go to hell or that we would burn in hell because we didn't have a mummy or a daddy and that they did not want us. We were constantly told that nobody wanted us and that we were dirty. I was always terrified of dying."[351]

245 **The name-calling, denigration of parents, lack of care for sick boys, the emotional impact of physical punishment, and the lack of individual care in these examples all constitute emotional abuse as well as unacceptably poor childcare practice, and we consider them to have been systemic abuse.**

Sexual Abuse by Staff

246 None of the allegations of sexual abuse involved the nuns, though there were examples in the later years of inappropriate sexual behaviour on the part of some sisters. SR 62, for example, was seen walking in the

346 SNB 397.
347 SNB 098.
348 SNB 100.
349 Day 84, pp.121 to 123.
350 Day 84, pp.122 to 123.
351 SNB 741.

nude through the children's dormitories, and SR 63 released her from her duties.[352] SR 18 was also alleged to have acted improperly, as referred to at Complaint L below. She ceased to work in childcare.

247 Seven allegations of sexual abuse were made, of which five related to gardener/handymen. HIA 159 said that in the 1950s a young man, NL 71, abused small boys.[353] We know no more about this allegation and have to conclude that it cannot be seen as indicative of systemic abuse at that time.

248 HIA 56, who was at Nazareth Lodge from 1959 to 1968, said that he was sexually abused by NL 116, the maintenance man. HIA 56 pointed him out to SR 47 as the man who had done "dirty things" to him but he could not recall her reaction.[354] NL 10, the gardener also abused him in his bedroom, which was the projector room above the main hall, accessed by a stone staircase.[355]

249 In written evidence HIA 147 wrote that NL 10, the gardener took him into the toilets near the concert hall to masturbate him.[356] In oral evidence he gave a graphic description of the way that the gardener also buggered him. He felt that he would have survived life at Nazareth Lodge if it had not been for the sexual abuse he suffered, but that this had ruined his life and his children's lives, making Nazareth Lodge a "hell home".[357]

250 HIA 36 said that he and another resident HIA 56 were out of bounds when apprehended by the caretaker, who took them to the boiler house, where he made them strip as it was very hot, and fondled them. This happened on three occasions, and once a nun called for them but did not go down the steps in the boiler house and so was unaware of the abuse.[358]

251 HIA 10 alleged that NL 14, the groundsman (who was married to a member of the care staff) had wandering hands and had pretended to tickle her, but had groped her.[359] This allegation was denied by NL 14, who pointed out that he was never employed at the home, though he had helped coach the boys in football as a volunteer.[360] Her sister

352 Day 112, pp.202 and 205.
353 SNB 594.
354 SNB 466.
355 SNB 465-466.
356 SNB 32084.
357 Day 87, pp.87 to 88.
358 SNB 426, Day 86, pp.21 to 25.
359 SNB 749.
360 SNB 80099.

alleged that NL 151, another groundsman, had interfered with her on the bus.[361]

252 HIA 154 said that a caretaker, HIA 135 abused him, starting with giving him sweets, moving on to mutual touching and then anal rape. HIA 154 was under the impression that the caretaker was aware of what Fr Brendan Smyth was doing.[362]

253 According to HIA 41 a temporary female member of staff from South Africa lay on the floor, undid her belt and trousers, and asked him to put his hand down her trousers; he found this humiliating and declined to cooperate.[363] HIA 210 said that he was sexually abused twice by NL 67, the Irish Dancing teacher, who fondled him while cleaning HIA 210 after he had soiled himself, and when staying in the teacher's house. HIA 210 said that he told SR 62 that he wanted to give up dancing, and that she punched him on the nose, making it bleed.[364]

254 Fr Steele, who was chaplain to Nazareth Lodge from 1988 to 1990, was convicted of sexual offences against children between 1969 and 1983, but he later admitted further offences and it is not known if any of his offending was against children at the home.[365]

255 HIA 56 and HIA 210 both reported the abuse they suffered, and it is clear that SR 62 was not prepared to believe HIA 210. The refusal to give credence to such allegations or to take action was in keeping with the general disbelief at that time that adults would commit such offences. If action had been taken on the first occasion it might have dissuaded others from abusing the children.

256 Otherwise, the Sisters may well have been unaware of the other instances of sexual abuse reported by witnesses. In view of the five instances in which they were involved, it could be argued that the Sisters should have supervised the gardener/ handymen more closely, but there is no reason why they should have suspected them of sexual abuse. Clearly SR 47 should have taken HIA 56's complaint seriously, but we have insufficient information to judge what transpired. We do not, therefore, consider that the Sisters were responsible for systemic abuse in failing to identify the risks posed by the male staff.

361 SNB 749.
362 SNB 883.
363 SNB 442.
364 SNB 601.
365 SNB 9145-9146.

Fr Brendan Smyth

257 Fr Brendan Smyth was a member of the Norbertine Order and he travelled widely, abusing many children. He was eventually convicted of child abuse and he died in prison. The Order accepts that Fr Brendan Smyth visited Nazareth Lodge, his first contact being a successful week-long religious retreat which he provided for the Sisters in January 1976, when he was accommodated in a room near the parlour.[366] Fr Brendan Smyth is the subject of a separate chapter of this report, where the systemic failures concerning his suitability and supervision are addressed. However, it should be noted that while visiting Nazareth Lodge he assaulted both boys and girls, and there are indications in the evidence that SR 46 and Mother Superior had some awareness of the threat he posed.

Physical Abuse by Older Boys

258 Several witnesses spoke of physical abuse by older boys. In the earlier decades of Nazareth Lodge, boys remained in the home until they were of working age. The problem was exacerbated because the nuns left the older boys in charge while they worshipped as a community in the evening. Since the nuns relied on the older boys to act as "class boys" or "charge boys", as they were known, they tended to accept their accounts of incidents, and the younger boys therefore had no means of seeking protection or redress.[367] The following examples all indicate the feeling of helplessness which the witnesses experienced in the face of bullying.

259 HIA 64 said that on wet Saturdays the charge hands picked out boys to fight each other, mismatching the opponents, until one was beaten or blood was drawn, and so he had to learn to stand up for himself.[368]

260 HIA 204 who was at Nazareth Lodge from 1929 to 1936 said that older boys bullied him and manipulated him to confess to a priest that he had broken a statue of Our Lady, which had in fact been broken by an older boy. He told his mother about the abuse, but she did nothing as she feared that the nuns might discharge him from the home. He respected his mother and so did not tell her about sexual abuse he had also suffered.[369]

366 SNB 1972.
367 SNB 464.
368 SNB 479.
369 Day 82, pp.8 to 9 and 14 to 15.

261 HIA 99 said that older boys threatened to hit them with hurley sticks at night. He thinks this was so that the younger boys would cover their heads with blankets so that they could not see the sexual abuse committed by the older boys. HIA 24 endorsed this view.[370]

262 HIA 427 said that the nuns had older boys as pets, and these pets pulled their hair, hit them against the wall or hit them on the head. They made him so afraid that he soiled himself and they made him eat his faeces. He felt that his hands were tied and no one was there to help him.[371]

263 HIA 33 said that SR 118 nominated "class boys", who were boys of the same age as HIA 33, but were put in charge in the sisters' absence. They had the authority to punish boys by making them kneel by their beds or in the corridor with their hands above their heads, for example for talking at night in the dormitory or for lying in bed without crossed arms. If the class boys reported misbehaviour to SR 118, she always accepted their word, and boys brought in front of her were beaten with a large belt.[372]

264 HIA 307 said he was intimidated, belted and bullied by older boys. The nuns knew, but he thought that they might have been scared of the bigger boys. Boys who complained were told:

> "'That didn't happen and if you say that again I'll box your ears'. One of the worst parts of life was the feeling of helplessness. We had no one to turn to".[373]

265 HIA 87 said that there was nobody to whom he could complain. If he told the priest in confession, the priest then told the nuns, and they told the boys, and he was beaten. He alleged in particular that HIA 192 was "an evil boy" and regularly hit him; he woke up with blood on his pillow. He said that he:

> "cannot really blame the other boys because they did not know any better; I can only blame the people that were administering the rules and regulations".[374]

266 When Rubane was opened in 1953 and boys from Nazareth Lodge were transferred there at the age of eleven, the amount of bullying suddenly dropped, and although there were some instances in subsequent decades, bullying does not seem to have been such a major problem thereafter.

370 SNB 279, 418.
371 SNB 564.
372 SNB 1640-1641.
373 SNB 099.
374 SNB 258.

267 It is unsurprising that there was bullying within a large group of boys, many of whom had come from homes where they had witnessed or experienced violence as a way of dealing with relationship difficulties and asserting power. It was for the Sisters to prevent or at least reduce the bullying and create an atmosphere in which the boys were encouraged to befriend and support each other instead. Since there was only one sister to each group of thirty boys in the early years, this was almost to ask the impossible. HIA 368 said:

> "There was a lot of fighting between the boys, so we had to be able to look after ourselves."[375]

268 However it was the Order which had offered to take on this work and to continue to run the home despite the abysmal staffing levels. Their solution in the early decades of selecting older boys to act as charge boys or class boys was understandable if the community was to enjoy a brief respite each day to come together, to worship and, no doubt, to benefit from the support and solidarity of the group. **However, it was the use of charge boys which predictably led to the most serious bullying. To rely on the older boys to control the younger ones in this way was a systemic failing.**

269 There was little evidence of peer abuse after girls were admitted. HIA 363, who was admitted to Nazareth Lodge in 1977, said that on her first night in the home two older girls bullied her in the girls' bathroom to make her curse, banging her head off the sink, until she gave in and said the 'F' word.[376]

Sexual Abuse by Other Boys

270 In the descriptions of physical abuse by older boys above, there are general references to sexual abuse. Eleven witnesses alleged sexual abuse by peers. Of these, six were in Nazareth Lodge before Rubane was opened, when there were numbers of older boys in the home. Four were in Nazareth Lodge in the 1960s, when presumably there were still some older boys who had not been transferred to Rubane. No other witnesses who were boys at Nazareth Lodge alleged sexual abuse by peers from the 1970s onwards, perhaps because nearly all those aged over 11 had been moved to Rubane. One girl made an allegation, probably relating to the 1980s.

375 SNB 657.
376 CLO 1003.

271 It was on 3 April 1929 that HIA 204 was admitted and placed in the nursery unit, prior to moving to a unit for older boys run by SR 118. While the nuns were dining or praying the senior boys were in "full control". The nuns did not enter the bathroom and so the senior boys took advantage of the smaller boys, making them "perform impure acts".[377]

272 In the 1930s, when HIA 408 was aged six or seven, NL 80 took him to the sewing room on the top floor and made him masturbate him. HIA 408 had nightmares about it and he said that it still upset him. A few weeks later NL 80 stripped and beat him in the toilets. HIA 408 told his brother NL 142, who was in the Merchant Navy, about the abuse, and it stopped.

273 HIA 24 said that in the 1940s older boys sexually abused younger boys in the dormitories at night, including NL 46 and NL 39. He was made to masturbate two older boys but he refused to participate in oral sex.[378]

274 HIA 99 was sexually abused by an older boy when he wet the bed. He said that the older boy terrified him.[379] HIA 89 said that when he was aged about nine, two older boys, NL 46 and NL 47 who were aged fourteen or fifteen, abused him. He said that he screamed and managed to run away, but afterwards they bullied, slapped and punched him and made his life hell, because he had not complied sexually.[380]

275 HIA 214 was made to masturbate older boys in the dormitory at night and he said he was buggered on two or three occasions by an older boy, which made him frightened to go to the toilet at night, such that he wet the bed.[381]

276 HIA 307 said that he suffered sexual abuse many times by older boys in the bathroom; it consisted of fondling and was not penetrative, but it groomed and prepared him for the abuse he later suffered in Australia. When lining up for the baths, the older boys helped the younger boys in and out, and in the process they grabbed their penises or stuck fingers up the younger boys' backsides in a manner that was "kind of jocular". There was a supervising sister, but the sisters were frightened of the older boys, and they did not intervene.[382] He felt that the nuns were negligent in not doing anything about abuse by older boys.[383]

377 SNB 305, Day 82, p.7.
378 SNB 418.
379 Day 82, p.69.
380 Day 83, p.17.
381 SNB 309.
382 Day 84, pp.15 and 16.
383 Day 84, p.17.

277 HIA 36 said that HIA 147 tried to abuse him sexually in a large dog kennel that had been used to keep Alsatians, but he threatened to tell his mother and the other boy, who denied the incident, desisted.[384] HIA 56 said that he was sexually abused by two older boys under a table on the stage in the hall and in the henhouses; indeed the two boys fought over which should abuse him.[385]

278 HIA 19 said that he was sexually assaulted by two charge boys, that NL 5 witnessed one occasion, and that he reported the incident to SR 47, who brushed it off and would not believe him, as she knew that he did not like the charge boys.[386] HIA 355 had recollections that when he was a four-year-old someone, probably an older boy, lay on top of him and ejaculated on three occasions, but did not penetrate him.[387]

279 As with the allegations of physical abuse, some sexual experimentation and some exploitation of younger boys is not surprising. Some of the alleged abusers were named by more than one witness and there is no reason to doubt their evidence. However, it was for the Sisters to provide adequate supervision and reduce the opportunities for abuse, and there were clearly times when supervision by the sisters was non-existent. They should have anticipated that such abuse was likely and arranged for supervision throughout the evening and early night-time when the charge boys were left in control.

280 In leaving the care and control of the younger boys to the older charge hands, the opportunities for sexual abuse were increased, and this amounted to systemic abuse.

281 HIA 363 described an incident in which a boy invited her to his den and tried to involve her in oral sex. She told his brother, who hit him. The boy got a bread knife and slashed HIA 363's hand, which had to be stitched at Belfast City Hospital.[388]

282 Jim Tracey said that in his eight years working at Nazareth Lodge from 1984 to 1992 he never witnessed abuse by an adult but he was aware of peer abuse, both physical and sexual:

> "...and these cases were duly and effectively managed under child

384 Day 86, pp.29 and 30.
385 SNB 466.
386 SNB 406-407,409.
387 SNB 368.
388 CLO 1006.

protection procedures and managed by the Child Case Conference process, chaired by the statutory children's services".[389]

Inspections

283 Up to 1951 Nazareth Lodge was inspected annually as an industrial school by Inspectors from the Ministry of Home Affairs. A number of inspection reports have survived from this period, generally indicating approval for the quality of care offered.[390] From 1951 Nazareth Lodge was registered as a children's home, and it seems that thereafter it was subjected to a lighter touch, with visits, rather than inspections, undertaken by inspectors such as Miss Forrest.[391]

284 Nonetheless Miss Forrest was perceptive and did not hold back from sharp criticisms. She visited on 9 January 1954. Following her earlier concerns, the babies and toddlers were now looked after better, and the older boys had moved to Rubane. Miss Forrest felt that it was the school-age boys who had lost out as a result.

> "We saw little 5 and 6 year-olds sitting in a row with bare legs and feet waiting to get washed before supper. A slightly larger child stood facing them, hissing at them to 'stay quiet'. Some of this stillness and quietness was probably for the benefit of the visitors, but what an unnatural state of affairs! About half a dozen of these 'little shrimps' were making up the beds with the help of the one nun in charge. Two unfortunates who had soiled their pants were standing dressed in underpants only, on the tiled floor of the bathroom, waiting to be cleaned up and looking very miserable. What is needed here is really fundamental reorganisation so that these little creatures can have some individual loving care instead of being dragooned."[392]

285 The Hughes Inquiry was critical that the only SWAG report extant for Nazareth Lodge for the period 1973 to 1983 related to an inspection carried out in 1983 which was after the abuse in Kincora came to light. It accepted that Social Work Advisers had visited the home on four occasions within that ten year period but found the level of inspection to be unsatisfactory. The Department of Health has acknowledged that its predecessor bodies failed in this respect. **We agree with the conclusion of the Hughes**

389 SNB 2201.
390 SNB 1963, 13649, 13708.
391 Day 117, p. 29.
392 SNB 16116.

Inquiry and consider the lack of inspection of Nazareth Lodge in that period amounted to a systemic failing by SWAG to ensure the home was meeting statutory regulations and providing proper care.

286 Victor McElfatrick was an inspector with the Social Work Advisory Group when he and Norman Chambers conducted an inspection of Nazareth Lodge from 10 to 12 October 1983. At this time the home was registered for 58 children, but it was accepted that it was unlikely that the number would exceed 40, and one of the four units was closed.[393] It was noteworthy that 25 of the 36 children then in the home were members of sibling groups and with one exception the families had been kept together in the same groups.[394]

287 There was thought to be much room for improvement, with poor staffing levels, rigid management, petty rules, lack of individual work with children, and a preoccupation with cleanliness.[395] There was no record of important events, and therefore no details of monthly statutory visits.[396] Only one sister was qualified in residential childcare, and hers was the only unit where the running of the group could be considered "residential social work", involving primary workers for the children and letting the lay staff read the case files.[397] It was recommended that staff should be seconded for Certificate in Social Services or Certificate of Qualification in Social Work courses.[398] The management style of the home was autocratic; three sisters were each in charge of a unit and they tended not to consult with their lay staff, who had little opportunity to influence practice, which limited their job satisfaction.[399] All the care staff were female, and the inspectors felt that the appointment of men as male role models would help.[400] The staff did not eat with the children as they found the food (which was prepared in a central kitchen) unappetising. The inspectors found this practice institutional and recommended changes.[401]

393 SNB 50494.
394 SNB 50508.
395 SNB 9148.
396 SNB 9149, 50516.
397 SNB 9148.
398 SNB 50507.
399 SNB 50503.
400 SNB 50506.
401 SNB 50513, 50514.

288 There are two versions of this report. The first is what Victor McElfatrick referred to as an "aide memoire", though it reads like a draft report.[402] The full report, which contained nineteen recommendations, was signed by Norman Chambers, who had discussed the contents of the report with Victor McElfatrick on 17 or 18 October. It contained a number of criticisms, such as the undue amount of staff time spent on practical tasks, the lack of male staff, the gulf between the sisters and the lay staff, the small number of parents visiting and the practice of sisters eating separately from the children.[403]

289 There are, however, several discrepancies between the two versions, with the second version generally toning down or omitting the sharper criticisms of the first. An observation that the nuns' religious duties were "intrusive" and "paramount", for example, was omitted, and the description of the emphasis on chores in one of the groups as "excessive if not obsessional" was toned down.[404] All but one of the lay staff were resident and they worked between 56 and 70 hours a week, often doing split shifts, with poor living conditions and low pay.[405] By this time residential childcare workers in the statutory sector had much improved conditions and pay. The lack of individual care and the absence of independence training for adolescents were also noted.[406] Of the three sisters responsible for the groups, one was seen as competent and social work trained and "this was evident in her approach to the residential task"; one was newly arrived; and one "had little understanding of residential social work and her ideas are largely irrelevant to the statement of aims and objectives".[407]

290 Victor McElfatrick could not explain the discrepancies, nor how the Sisters were to become aware of the Inspectors' concerns if they only received the gentler revised version.[408] Norman Chambers said that lengthy lists of recommendations could be overwhelming, so that his practice was to focus on critical issues and seek to encourage good practice.[409] His opinion, however, was that:

402 SNB 14316-14322.
403 SNB 50492-50521.
404 SNB 14317.
405 SNB 14321.
406 SNB 14322.
407 SNB 14322.
408 Day 111, pp.76 to 78.
409 Day 117, p.89.

> "Nazareth Lodge appeared to be caught in a time-warp of institutional practice, while at the same time some other voluntary children's homes were actively promoting the professionalisation of residential child care, bringing it more into line with field social work standards of practice."[410]

Dr Hilary Harrison said that following discussion the aide memoire "may have been justly modified".[411]

291 Retrospectively Victor McElfatrick thought that the report should perhaps have been more critical of the lack of a log, which prevented any assessment of the Sisters' compliance with the requirement for external monthly visits. He also felt that the inspectors should have been more specific in ensuring that volunteers were cleared by the Board responsible for a child who was being visited.[412] Norman Chambers felt that the monthly visiting requirements should also have been clarified.[413]

292 The inspectors:

> "did not come across any harsh treatment of the children or unacceptable methods of discipline."[414]

This observation was significant in view of the dispute about the investigation of complaints made in the following years by children who had been in Nazareth Lodge at this time, (see the next section of this chapter). However, they did suggest that the home would have to make changes if it were to meet the needs of adolescents with difficult patterns of behaviour, who were likely to be their clientele in future.[415]

293 The normal practice was for a letter to be sent to the head of home, to which SR 143 responded,[416] followed up by a meeting with the inspector. However, short of deregistration SWAG had no sanctions which it could apply to enforce its recommendations.[417]

294 Felicity Beagon was an inspector from 1987 to 1994, and she inspected Nazareth Lodge on five occasions from 1988 to 1992, on each occasion considering the purpose of the home, the resident group, the staff, the

410 SNB 9159.
411 Day 118, p.19.
412 SNB 9149.
413 SNB 9157.
414 SNB 9148.
415 SNB 50521.
416 SNB 50406-50411.
417 Day 111, p.105.

premises, compliance with regulations, monitoring arrangements, the complaints procedure and the home's financial position.[418] She inspected the records, such as the menus, the fire drills book and the punishment book, as well as meeting the children informally.[419]

295 She found the home to be run satisfactorily with a good standard of care, despite a high staff turnover. The per capita rate agreed with the Eastern Health and Social Services Board was raised from £287 to £450 to increase staffing levels and salaries for the secondment of staff to take Certificate in Social Services courses.[420]

296 Felicity Beagon was concerned about the institutional nature of the premises and she recommended that the three groups should be located in smaller units in the community. She never received any complaints from children or staff.[421]

297 Marion Reynolds inspected Nazareth Lodge between 4 and 11 January 1993, taking 58 hours over the inspection.[422] By this time the three units within Nazareth Lodge were looked on as separate homes. Marion Reynolds had worked primarily with the Eastern Board where there had been a range of small homes and she therefore found the large homes institutional, but attempts had been made to personalise care. She said:

> "…the Sisters had made considerable effort to personalise the homes, to make them domestic in nature, and they had done that as much as they could, given the structure of the building and the premises that they had, but I felt that because of where policy was going, these homes were in transition. They had been very large. They were reducing in size and to me it was inevitable at some stage in the future these homes would no longer have a function, but in the meantime they should operate in a way which was as domestic as they could make them…"[423]

298 Marion Reynolds noted a number of key issues:

- A plan to have four specialist units
- A plan for each unit to have intake function

418 SNB 9001.
419 SNB 9002.
420 SNB 9002.
421 SNB 9003.
422 SNB 9036.
423 Day 114, p.12.

- Doubts about admitting younger children short-term
- The inadequacy of staffing, without leeway for problems and to cover summer holiday
- Central lighting control
- Variability in the log
- Differences in delegated powers
- Unrecorded complaints
- Access to phones
- Admission criteria
- Sleeping arrangements concerning a known abuser sharing a bedroom with an abused child
- The lack of night staff for abused children
- The need for Team Leaders to have time to manage.

299 Although it was said that Castle Priory staffing levels had been adopted, her main concerns were with aspects of the staffing where she felt that cover was too thin to deal with crises, summer holidays and night-time cover without undue reliance on the sisters. Staffing was not inadequate, but was not ideal.[424]

300 In oral evidence, Marion Reynolds spoke about the differing personalities of the three sisters who managed the units; one of the problems in the structure was that other staff felt that there was a gap between the sisters and themselves and that they had too little delegated authority.[425] Her recommendations caused concern at the Nazareth Lodge Management Committee in view of the cost of the additional staffing required.[426]

301 After the 1994 inspection it was said of Nazareth Lodge:

> "It works on a one-to-one basis, trying to nurture and stretch children to the best of their ability. Nazareth Lodge provides high standards of physical and emotional care for children - it emphasises treating children as individuals. It delivers a high level of primary care and work in social and personal developments despite the adverse structure and layout of the building."[427]

424 Day 114, pp.53 to 54, SNB 15330-15331.
425 Day 114, pp.44 to 45.
426 SNB 9041.
427 SNB 13877.

302 As the conclusion of a formal inspection, this was high praise, and it is significant that very few allegations have been made to the Inquiry about this period. Although the buildings were still far from ideal, the quality of care appears to have been good.

303 In October or November 1995 Judith Chaddock conducted a brief inspection of Nazareth Lodge, including an examination of the monitoring system and the operation of the complaints procedure. The framework for this report consisted of a number of children's rights, which were considered in turn.[428] None of the Boards appear to have had concerns about the home at this time.[429]

Investigation of Complaints

304 It is significant that we have information concerning only one complaint from the records of Nazareth Lodge's earlier decades, two from the 1970s, and ten in the decade from 1984 to 1995, a period when good standards of care had been established. While the grounds for some of the complaints verged on the trivial, some were important, and two investigations raised points of principle. They are addressed below in date order.

Complaint A

305 In May 1927 NL 161 was hit with a stick (his version) or a strap (the Mother Superior's version) for bedwetting. A medical certificate indicated that his hands were swollen and there were marks on his thighs consistent with a beating with a strap. The police concluded that there was no doubt that NL 161 had been severely beaten but the evidence was insufficient to support a prosecution for cruelty. An inspector from the Ministry of Home Affairs visited Nazareth Lodge and interviewed the boy, who was in hospital. He "pointed out with some care" that it was an "acknowledged fact" that punishment was ineffective as a way of dealing with bedwetting, but it appeared to be the sisters' normal response. NL 161 also soiled, which the inspector felt was perhaps deliberate.[430]

Complaint B

306 In June 1976 NL 57, who was the sister of HIA 41, told her social worker NL 187 that SR 62 had hit her, but NL 187 did not believe her, as she

428 SNB 13816.
429 SNB 9137.
430 SNB 13659-13668.

thought that NL 57 and SR 62 had a good relationship. NL 187 recorded the allegation and informed her senior.[431] NL 57 stayed at Nazareth Lodge for a further five years, but it was only in 1990 that she complained to the police that SR 62 had punched her in the mouth and eye. The police investigated, and SR 62 denied hitting NL 57.[432]

Complaint C

307 While on a work placement at Nazareth Lodge in 1984 NL 162 raised three complaints. First, she witnessed a residential social worker NL 163 putting soap into the mouth of NL 157 for swearing, which made him retch and vomit. NL 162 reported this to the Eastern Board who, together with SWAG, interviewed the boy. SR 143 conducted an internal investigation and the residential social worker said she had acted "playfully", and that SR 52 had rubbed shampoo on NL 157's mouth for the same reason. Both staff were reprimanded and the incident was reported to the Eastern Board and deemed closed.[433]

308 Secondly, NL 162 said that children who had misbehaved were placed in a cloakroom infested with cockroaches. The SWAG inspector found that the room was light and airy and the infestation had been treated, though there was a sitting room which was more suited to time out.[434]

309 Thirdly, NL 162 reported that a major retailer passed on unsold food to the home. Upon investigation, this was considered acceptable.[435]

Complaint D

310 HIA 210 was fostered on leaving Nazareth Lodge on 9 August 1981 after eight years in the home. NL 190 was his social worker from 1978 to 1982, which covered the greater part of the period to which his allegations referred, but she said she had no recollection of the issues of which he complained at the time, although HIA 210 said that he had told her that SR 62 had hit him with a stick.[436] NL 180 then took over as HIA 210's social worker.[437] While in foster care he suffered severe nightmares which awoke his foster carers, and he disclosed mistreatment at Nazareth Lodge to his foster carers about November 1984.[438]

431 SNB 7180.
432 SNB 62431, 62455-62474.
433 SNB 9160-9161.
434 SNB 9161.
435 SNB 7372, 9142, 9162, 18977-19012.
436 SNB 6069-6071.
437 SNB 6083-6085.
438 SNB 42231.

311 NL 180 interviewed HIA 210, first on his own and then with his senior social worker (NL 191) on 21 February 1985.[439] HIA 210 alleged that he had been hit by SR 62 with a vacuum cleaner hose and with a stick; he had been locked in a cupboard and in a bathroom overnight, and he had been given a cold bath for complaining to a social worker.[440] It was felt that the substance of his complaints could have explained his nightmares. On 3 April 1985, HIA 210's brother was interviewed; he had some difficulties remembering, but while he did not corroborate some of HIA 210's complaints, his recollections were not discrepant.[441] The events in question were already between four and twelve years earlier.

312 NL 180 believed there was "some substance" in the allegations.

> "When [HIA 210] was telling the actual incidents, ...he seemed to relive part of them. He was also, I think, generally an honest child. He wasn't one that could create elaborate deceptions".[442]

From this point responsibility for investigation moved up the line from the social worker to the senior staff.[443]

313 The senior social worker's report was dated 11 April 1985.[444] She too believed the allegations credible and reported the allegations to NL 223, Principal Social Worker.[445] He in turn wrote to Bob Bunting, Assistant Director, on 30 April 1985, noting that other Boards or units might be involved.[446] By this time SR 62 and NL 66, against whom HIA 210 had made allegations, had both left Nazareth Lodge, so that there appeared to be no immediate risk to children.[447]

314 NL 223 and the senior social worker interviewed HIA 210 on 21 June 1985. After consultations involving Bob Bunting, the Director of Social Services and the Chief Social Work Adviser, the Director asked NL 223 to write to SR 143, then Mother Superior of Nazareth Lodge, which he did on 27 June 1985, detailing eight specific complaints and suggesting that SR 143 and he should speak to two members of staff who knew HIA 210, NL 146 and NL 147 (one of whom had left by this

439 SNB 6086-6091.
440 SNB 6081.
441 SNB 6081.
442 Day 104, p.53.
443 SNB 6085.
444 SNB 6089.
445 SNB 6087.
446 SNB 6091.
447 SNB 6084-6085, 7015.

time) about their time in the unit.[448] NL 223 interviewed them, and while their memories did not corroborate HIA 210's allegations, he felt that the allegations were credible and warranted fuller investigation.[449]

315 NL 223 felt that the Department should have investigated the complaints, as he had:

> "no power to interview staff, access to Nazareth House records or for that matter interview children from other Boards or Districts",[450]

and on 18 February 1986 he wrote to Bob Bunting, stating:

> "I honestly believe that I can take this matter no further as I do not feel that I have the authority to deal with any of the issues that this incident now raises and I would ask to be freed from any further involvement in this issue until matters of accountability have been clarified."[451]

Perhaps because of pressure of work, there was no response to this letter until 30 April 1986.[452]

316 The Department suggested at one point that some of the complaints could have been seen as relating to child protection, such that the police should have been involved. Child protection procedures had been drawn up first in 1972 and revised at intervals, though it was not until 1991 following the publication by the DHSS of *Co-operating to Protect Children* in 1989[453] that a Joint Protocol was agreed. Under the procedures in force in 1985, police were to be notified of abuse, and a case conference was to be held involving the police, who were to notify the Board of any intended action. It was felt at this time that the evidence was not strong enough to warrant involving the police.[454] The Department's recommendation to involve the police was therefore not immediately followed up. When offered support in approaching the police in February 1987 HIA 210 declined.[455]

317 Indeed, one of the contextual problems for this Inquiry was that, following a consultation paper in October 1983, the Department had issued a draft Complaints Procedure in August 1984 and a final version on 30 April 1985. This was published as DHSS Circular HSS (CC) 2/85 and

448 SNB 6079-6080.
449 SNB 7016.
450 SNB 7019.
451 SNB 7028, 7032-7033.
452 SNB 6924-6925.
453 SNB 9168, 9286-9293.
454 SNB 7480.
455 SNB 7017.

it was applied in the voluntary homes (with one exception) from May 1985. However, the trade union NIPSA declined to co-operate in its implementation in the statutory sector without safeguards for residential childcare staff.[456] Following widespread consultations and negotiations, a model procedure drafted by the Northern Board was eventually agreed for use throughout the province. The Hughes Report commented on the necessity for a Complaints Procedure[457] but in the event it was 1991 before the Procedure was fully implemented, possibly delayed by the time required to train staff.[458] The draft Complaints Procedure did not, in any case, specify the way that investigations were to be carried out, leaving it to the Boards to decide on the processes which suited them best, while reflecting a number of key points of principle which had been laid down.[459] It was, for example, up to Directors of Social Services and heads of voluntary bodies to decide whether to involve the police in the event of allegations of criminal activity. Where allegations related to voluntary homes, the heads of the agencies and Directors of Social Services were expected to collaborate.[460]

Complaint E

318 While the enquiries concerning HIA 210 were proceeding, NHB 136 a social worker working for the North and West Belfast Social Services, had some concerns about Nazareth Lodge, but discussion with SR 52 satisfied her. However, in her work with an 18-year-old former resident, NL 145, who had been in Nazareth Lodge from 1979 to 1985, she learnt of physical abuse perpetrated by SR 62, who had retired from childcare by this time.[461] Colleagues who had visited the girl when she was resident had been unaware of the abuse, though NL 145 insisted that she had tried to tell social workers, but no one had taken her seriously.[462]

319 Following preliminary investigation by the social worker, (as the complainant was only disclosing by stages), NHB 136 reported to NL 223, who on 26 November 1985 informed Bob Bunting and Robert Moore, the Director of Social Services in the Eastern Health and Social Services Board, who took the matter up with Mr P.J. Armstrong, Chief Social Work Adviser for

456 SNB 9043.
457 SNB 7037-7046.
458 SNB 7019.
459 SNB 7039, 9043.
460 SNB 9044.
461 SNB 6267.
462 SNB 6266, 7030.

the Department of Health and Social Services. The Department argued that it was for the Board to investigate, in view of their responsibility for the girl's welfare. The Board argued that SWAG was responsible as the allegations could have amounted to general malpractice and physical assault. Dr McCoy, Senior Social Work Advisor decided that there were insufficient grounds to investigate.[463] In any case, formal inspections of Nazareth Lodge had taken place in October 1983 and January 1986 and they had found no "adverse comment on the harshness of the regime".[464]

Complaint F

320 HIA 210 had referred to NL 97, who was in the care of the Northern Board, and the Director of Social Services of the Eastern Board therefore wrote in June 1985 and arranged for NL 223 to interview him.[465] NL 97 corroborated the allegations made by HIA 210 and NL 145, saying that SR 62 had picked on him and HIA 210 and that SR 62 had beaten them with a wooden spoon and a bamboo cane, on one occasion banging his head against a wash-basin and causing him to bleed. NL 97 also expressed affection for SR 62.[466]

321 The Director wrote to the Chief Social Work Adviser on 30 April 1986, saying:

> "There can no longer be any question that the information we now have available from three former residents amounts to alleged general malpractice and in some instances physical assault by [SR 62]".[467]

322 SR 143 investigated in 1986. It should be noted that by this time it was five years since HIA 210 had left Nazareth Lodge and more than a year since he had first disclosed his complaints.[468] SR 143, then the Mother Regional, did not speak to any young person nor to the professionals who had talked with the complainant. She interviewed six people who had been members of staff during the relevant period, and she put the issues raised by HIA 210, NL 97 and NL 145 to them. The former staff all denied witnessing any of the incidents with one exception. NL 66 had seen SR 62 hit HIA 210, who was misbehaving, with a wooden spoon in the kitchen. SR 62 acknowledged that this happened on a few occasions. SR 143

463 SNB 19030, 19032, 19050-19054.
464 SNB 9139.
465 SNB 7016-7017.
466 SNB 7032.
467 SNB 7017, 7034.
468 SNB 6061.

considered her enquiries to have been "exhaustive".[469] Her conclusions did not satisfy the Board. It was 1987 before the correspondence on the issue came to an end without further investigations having been concluded.[470]

323 The Eastern Board Director of Social Services was dissatisfied with this investigation and arranged for all three complainants to be informed of the outcome and promised support if they wished to contact the police.[471] On 17 February 1987 Bob Bunting informed SR 143 that NL 97 and NL 145 intended to contact the police, though HIA 210 did not wish to.[472]

324 The length of time which these investigations took before they were concluded was noted by John Duffy in his evidence. He felt that the Complaints Procedure had not differentiated the responsibilities of the parties involved clearly. Paragraph 17 of Circular 10/1983 stated that Boards had to satisfy themselves about the standards of care being provided for each child they placed in voluntary homes.[473] However, it was the Department which registered and inspected the homes, and up to late 1985 inspection reports had not been made available to the Boards. Social workers could only assume that as registration had not been withdrawn, standards must have been satisfactory. In satisfying themselves about the standards of care they could only reassure themselves about the suitability of the home in terms of the gender and age of its residents, its siting and facilities, and their own experience from previous contact and informal comments gleaned from colleagues. Social workers were not in a position to make the sort of detailed inquiries which would be made in inspections.

325 Although joint liaison between police and social services had already been in evidence from the early 1970s onwards it was not formally set out in Joint Protocol procedures until 1991. John Duffy told us that had the Joint Protocol procedures been in place at this time the police would have been required to participate in joint interviews, thought would have been given to contacting other children who might have been affected and the whole matter would have been resolved more speedily.[474] As it was, although the investigations ended, matters were not resolved but ran into the sand. Dr McCoy acknowledged that it would have been better

469 SNB 7376-7377, 51778-51781.
470 SNB 19055-19058, 19068.
471 SNB 7017.
472 SNB 7036.
473 HIA 5713.
474 Day 117, pp.19 to 20.

if everyone had got round the table.[475] Indeed, there was a suggestion that a meeting might have been held between SWAG and the Eastern Board on 20 October 1986, but no notes of the meeting have survived.[476] The inspection undertaken in January 1986 was carried out in the full knowledge of these historical complaints but did not report any concerns about the current nature of the regime in the home. The DHSS Child Care Policy Branch therefore supported Dr McCoy's conclusion that no further action was required.[477]

326 It is our view that the Board was correct in its analysis. Three former residents had made allegations and had corroborated each other's accounts. Two Boards were involved. The allegations were serious, even if SR 62 had retired, and there were general issues involved, such as the quality of supervision and management. The Boards were not in a position to question the Mother Superior and Mother Regional. SWAG on the other hand was the registering and inspecting body and had the authority to investigate this matter. Passing the responsibility onto the Boards was in our view inappropriate, and the nebulous outcome of the enquiries was unsatisfactory. It should be stressed that in general, working relations between the Boards and SWAG appear to have been good. **It is our view that in this instance the Department failed to accept its overarching responsibility for ensuring that the safety of children in residential care was maintained. We consider that this was a systemic failing.**

327 The Department of Health responded to this finding as follows:

> "However, the Department wishes to stress again in the strongest possible terms that the investigation of historical allegations of child abuse was not a matter for Departmental Social Work Advisors within SWAG or Inspectors in the SSI. As noted above, this case concerned historical allegations made by children who were no longer in the home about staff who were no longer there. This type of investigation was neither suited to or appropriate to the role of SWAG which had to be concerned about current standards of practice in the home and whether the home should continue to be registered."

328 We find this line of argument unacceptable. In having an over-arching responsibility for social services the Department was accountable for all

475 Day 117, p.91.
476 SNB 100230.
477 SNB 9045.

aspects of the provision of the services, including historical concerns. There is, of course, the question as to when complaints would be deemed historical, and the line of argument put forward by the Department could be used to dismiss any complaint or practice concern which was not current. The residents and the staff had moved on in this instance, but questions remained whether other children might have been affected, why the home's management failed to be aware of the problems, and what action they had taken to prevent a recurrence, for example. The Boards could only seek the co-operation of the Order, and did not have the authority to press the questions which needed to be put. Only the Department, in the form of the Inspectorate, had that authority.

Complaint G

329 NL 269 was a residential social worker who worked at Nazareth Lodge from September to November 1992. He complained to Marion Reynolds, SSI Inspector, by phone about a number of issues of varying levels of importance. He felt he had to resign from the Lodge because of unsatisfactory responses from his Team Leader and Sister Superior when he had raised childcare issues.[478] Notes were taken of his call and read back to him.[479]

330 He was asked to put his complaints in writing, but did not do so, and Norman Chambers, Assistant Chief Inspector, told Marion Reynolds to take no further action. She told us that she was not happy with this decision, as ignoring complaints was contrary to her practice. Nonetheless she wrote to NL 269 to say that no further action was being taken.[480] It happened that Marion Reynolds had been undertaking an inspection of Nazareth Lodge and most of the issues raised by NL 269 had in fact been addressed in her report.[481]

331 NL 269 complained of the following:

- An incident of overtly sexualised behaviour not reported to social services
- The adequacy of sleeping-in arrangements
- An incident concerning drugs
- Residential staff needing permission to contact field social workers

478 SNB 9162.
479 SNB 19070-19071 and SNB 9039-9040,
480 SNB 9515.
481 SNB 9162-9163.

- A former resident who had abused a child and who had run of the house
- Staff being frightened
- Boys being left accessible to an abuser who was mother's cohabitee
- The absence of a role in the home for qualified staff
- The management of his concerns.[482]

332 Dr Kevin McCoy said:

> "The matters raised by [NL 269] were of a serious nature and should have been followed up with the home. There was no protocol either within the SSI or the wider Department that required such concerns to be conveyed in writing before being acted upon."[483]

Complaint H

333 At the 1992 inspection of Nazareth Lodge it was reported that one complaint had been made since the previous inspection – a mother alleging that her child had been beaten by staff. The child had been restrained by the staff. The incident was thoroughly investigated, recorded and explained to the parent, who withdrew her complaint.[484]

Complaint I

334 In 1993 three concerns were raised involving NL 260. First, in March he complained that confidentiality had been breached as another resident had approached him about abusing girls. Secondly, in April he said that SR 18 had locked him and another resident out until 2am. Thirdly, in May his social worker, NL 275, found him alone in his unit, as SR 18 had not taken him out with the others because of his behaviour.[485] One concern was whether such matters needed to be dealt with formally through the formal Complaints Procedure, which was now in operation.

Complaint J

335 As a social worker, NHB 137 supervised two young people at Nazareth Lodge. In 1995 NL 164 made a number of comments which could have been considered complaints, some of which impressed as being too trivial to be dealt with through the formal complaints procedure. He said that SR 18 had "poked" him, but he did not want to complain as he had provoked

482 SNB 9163-9165.
483 SNB 9144.
484 SNB 15252, 100252.
485 SNB 7373.

her. He alleged inappropriate sexual behaviour by another resident, but swift action had been taken. He had been locked in the kitchen by SR 18. Most seriously, SR 18 had put him off the minibus for misbehaviour, which had resulted in a 10-mile walk home. NL 170, a residential worker, wrote detailed reports of these incidents for SR 52 and Judith Chaddock, Inspector.[486]

Complaint K

336 Around the same time NL 168 complained in August 1995 of an incident in the office of Nazareth Lodge in which a staff member NL 227 restrained her. The residential worker in turn alleged that NL 168 had headbutted her, and the police were called. The investigation of NL 168's complaint was hampered when she and her mother consulted a solicitor who advised them not to comply with the Complaints Procedure.[487]

Complaint L

337 Soon afterwards NL 170 left Nazareth Lodge. She worked there from January 1994 to September 1995. While she was at the home, she made complaints to the Mother Superior, the social worker attached to the home NL 169 and NL 35; indeed she prepared a written report for SR 52, the Mother Superior, who told her to tell no one of its contents. She informed a social worker NHB 137, who she said asked her to tell him nothing more as there was nothing he could do.[488] HSCB have indicated that this account was at odds with NHB 137's contemporaneous records, which indicated that when NHB 137 spoke to NL 164 he told him that he did not wish to make any complaint, that NL 170 told him she did not wish to speak to him about the complaints, that she did not provide a report about the incident, even though he reassured her that any complaints would be investigated.[489]

338 Two months after she had left, as nothing had happened, NL 170 wrote to Judith Chaddock, an inspector. In all, NL 170 made fifteen complaints about Nazareth Lodge concerned with pay and conditions and a variety of childcare issues, confirmed in a letter dated 19 December 1995. NL 170 said she felt alone and isolated in raising these issues.

> "I had never worked in such an environment where there was silence, power and authority, all of which surrounded the nuns".[490]

486 SNB 17967-17977.
487 SNB 7373-7394, 49376.
488 SNB 7488.
489 SNB 6096-6097.
490 SNB 7486.

When she gave evidence to us NL 170 added to her complaints about SR 18 and alleged she had seen her lying naked on her bed surrounded by boys in their pyjamas and that there were also suspicions about her relationship with a former residence who lived in the independence unit.

339 Judith Chaddock notified each EHSSB Trust which had a child placed in the home by letter about the complaints she had received from NL 170, and copied her letter to the Regional Supervisor requesting the Regional Supervisor to investigate and report back.

340 NL 170's complaints were investigated internally by the Order, together with those made by NL 168 and NL 164. The Nazareth Lodge Management Committee set up a Complaints Subcommittee, with three members - Mother Hilary, Mrs McNally, who acted as Chair, and Alan Chard, a Programme Manager in Down Legacy Trust, as an independent observer. The complainants and SR 18 were interviewed and she made a partial admission, which gave the complaints some validity.[491]

341 The working group presented their report on 4 March 1996 (after the end of this Inquiry's remit) and was questioned closely by the Management Committee. Alan Chard felt that they were defensive; he was required to leave after the presentation of the report, and so was unaware of their conclusions.[492] SR 18, who had been the subject of many of the complaints, decided to withdraw from childcare.[493] Copies of the Management Committee minutes were circulated to the Trusts, but the full report was not shared and the minutes did not include responses to individual complaints, nor the rationale for action taken.[494]

342 According to Dr Kevin McCoy, the Department was unaware of any report on this investigation reaching the Inspectorate at this point.[495] However, in December 1995 Judith Chaddock wrote to the Regional Superior concerning several complaints about SR 18, attaching NL 170's handwritten reports.[496] The investigation of these complaints was complicated by numerous additional allegations made by NL 164, which he withdrew when visited by an investigating social worker, and by complaints made by NL 260. Since three children were involved, each

491 SNB 7377.
492 SNB 7049.
493 SNB 7049.
494 SNB 19320-19321.
495 Day 117, p.142.
496 SNB 17967-17977.

placed at Nazareth Lodge by a different authority, the correspondence covering these events is unusually detailed, continuing after the end of the Inquiry's remit. It is laid out in full in a report by John Duffy.[497]

343 The investigation undertaken by the Nazareth House Management Committee Subcommittee demonstrated that in this instance the policy for agencies to undertake internal investigations of complaints was unsatisfactory, proving to be defensive, secretive and ineffective. The policy had been followed, but none of the people who needed to know the outcome was provided with the necessary detail or the rationale for the Congregation's conclusions. As part of the Warning Letter process the Department responded that:

> "It would be inappropriate to regard voluntary organisations generally as being any less capable [than statutory trusts] of undertaking such responsibility now or at the time in question."

We question that judgement; for a voluntary organisation with a thin management structure to be able to undertake an independent inquiry is unrealistic. The principle of 'being a judge is one's own cause' applies. **We acknowledge that the Department was breaking new ground in drafting the Complaints Procedure at this time but we are critical that it included that agencies should undertake internal investigations of complaints and we are critical of the Sisters for conducting the investigation secretly.**

Complaint M

344 On 23 June 1995 Bob Bunting notified Norman Chambers that two retired priests were living at Nazareth Lodge. On investigation it was found that they had separate access and that any contact with the children was most unlikely.[498]

345 The number of complaints which were investigated during this decade should not be interpreted as a symptom of poor residential care. The inquiries did identify some physical abuse and other unacceptable conduct, particularly on the part of SR 62 and SR 18, both of whom left the work. The main message, however, is that throughout this period, the investigation of complaints improved. Children were probably being encouraged to voice their complaints. Social workers clearly took complaints seriously, though

497 SNB 7381-7389.
498 SNB 9170-9171.

the process following initial identification of a complaint proved at first confused and time-consuming.

346 It was only with the eventual adoption of the Complaints Procedure and the creation of the Joint Protocol for investigating child protection matters that satisfactory systems were set up. If anything, the main problem once the Complaints Procedure had been implemented was that trivial issues, such as squabbles between staff and children, were notified as complaints, and then often withdrawn. Nonetheless, for all the deficiencies of the systems, the contrast with earlier decades is sharp. Complainants were now being heard and refusal to believe that abuse was possible was a thing of the past.

Conclusions

347 During the period covered by the evidence of witnesses there were considerable developments in residential childcare, both in the standards of care expected and in the way care was delivered at Nazareth Lodge.

348 At the start, in the 1940s and 1950s, times were hard and there was limited money, so that staffing was minimal and food was basic. The situation at that time was summarised by the Inspector Kathleen Forrest in April 1953, writing about the four homes run by the Sisters of Nazareth:

> "The children in these four homes especially have nothing like a normal upbringing. They must feel unloved as it is just not possible for the number of staff to show affection to such large numbers of children…I find these homes utterly depressing and it appals me to think that these hundreds of children are being reared in bleak lovelessness. This is not meant entirely as criticism of the staff, but their task is impossible. …In short I think we must press for complete overhaul of the whole set-up of these homes and assist them in every way possible."[499]

349 If the drastic action proposed by Kathleen Forrest had been taken by the Ministry, it is quite probable that the number of applicants to the Inquiry would have been greatly diminished, but, as described in Chapter 5, it seems likely that the Department decided on minimum intervention.

350 By the end of the period, with the Health and Social Services Boards financing the children's care, staffing was much improved, though never generous, and living standards were much better. It is significant that the

499 HIA 1464.

number of allegations of abuse made by witnesses was greatly reduced in the later years.

351 Because of the limited resources available to the Order and because of their initial unwillingness to approach the statutory authorities for finance, the Sisters were slow to make improvements in staffing and living conditions, which were markedly better in state-funded establishments such as training schools and local authority children's homes. In consequence the children in Nazareth Lodge were enduring physical standards of care and a shortage of staff to whom they could relate in resolving their problems, which they would not have experienced if they had been in homes run by other agencies.

352 Finance for children in voluntary residential care could have been available from the implementation of the Children Act 1950, but no action was taken for over twenty years. This shortage of finance could therefore have been obviated much earlier. **We therefore conclude that the shortage of finance and its consequent impact on staffing levels and physical standards of care amounted to a form of neglect and constituted systemic abuse. Although both central government and the welfare authorities bore some responsibility, this was primarily the responsibility of the Sisters of Nazareth.**

353 For some children the quality of care was acceptable and a number have fond memories of the nuns. They saw Nazareth Lodge as home and some have maintained close links with individual sisters and with their peers. Some have expressed appreciation of the dedication of the nuns, who took them in when their own families could not - or would not - care for them, and who spent their lives in the work, often without any respite.

354 It is against this background that the range of views expressed by witnesses has to be seen. HIA 87 said that his time at Nazareth Lodge made him independent and gave him self-respect. As a result he was able to make decisions and take a long-term view.[500] HIA 159 appreciated the solidarity experienced with his peer group in the face of bullying by older boys.

> "But there was support there from your friends when you were punched or kicked by older boys, slapped or strapped by the nuns and when you fell and hurt yourself - a caring arm, a laugh and a joke, and it was soon all friends together in whatever game we were playing. Yes, we

500 Day 83, p.52.

did cry a lot at times, and laughed, for we knew that no one would look after us but ourselves".[501]

HIA 247 said that Nazareth Lodge had "A tough regime, but not all bad."

355 HIA 56 was at Nazareth Lodge in the late 1950s and 1960s, and he said:

"I never had any complaints about the nuns. The nuns were good and I have nothing bad to say about them. They made sacrifices for us. I just suppose they didn't see what was going on. Even today I miss them."[502]

356 Others were highly critical. HIA 159 felt that "Large homes have had their day." HIA 24 said that he did not think that homes were proper places in which to bring children up, as they did not learn anything about life, and when they were outside, they were lost. They had to learn from scratch without any help. In the homes they were not treated as individuals, but controlled as a group.[503] HIA 87 said:

"I feel that I was mistreated and humiliated in the home, which has left me psychologically and emotionally scarred to this day".[504]

He still had nightmares about beatings, and he had found both the Order and the Church obstructive when he was seeking to contact his relatives.

357 HIA 183 said "I do not remember any love or stimulation".[505] HIA 307 said:

"My life in Nazareth Lodge was bleak, harsh and cruel. The nuns were at best indifferent but more often were sadistic bullies who spoke with harsh loud voices in scornful, dismissive tones. They were quick to strike out and provided no reassurance or comfort to a small frightened child".[506]

358 That there was serious physical and sexual abuse, with strong connotations of emotional abuse, is clear. Having made allowance for possible exaggeration and faulty memories, the detail and sheer volume of these allegations, together with the strength of feeling of the witnesses, makes them credible, despite the denials by members of the Order. It may be hard to understand how nuns who had dedicated their lives to serve the disadvantaged should come to abuse vulnerable children so cruelly. It is

501 SNB 32189-32190.
502 SNB 467.
503 Day 83, pp.87 to 88.
504 SNB 261.
505 SNB 522.
506 SNB 097.

for this reason that the children's parents, the police and doctors did not believe their allegations; it was unthinkable that nuns would do such things.

359 In trying to understand how the abuse came about it has to be acknowledged that the boys could be mischievous, disruptive and challenging. Having, in many cases, come from broken families where they had experienced violence and poor parental care, it was not surprising if their own behaviour was also disturbed. Yet society's expectations were that the Sisters would contain, control and care for these children.

360 Some of the punishments could be interpreted as the attempts of sisters to retain control of their group of boys. The pressure that they were under through a dire shortage of staff has been acknowledged. It seems, however, that the only mechanism they knew for controlling children was to punish them and repress their misbehaviour. Their status, both within the home and in the wider community, gave them considerable power over the children, and the corruption which power can bring is well known.

361 The types of punishment described were unnecessarily cruel, they were contrary to the Order's Rules, and they breached the Children's Homes Regulations.

362 In attempting to provide a balanced summary, it has to be recalled that Nazareth Lodge was open for 112 years and that 2,909 children were admitted in the course of its history. Although the number of witnesses was larger than for most other homes we have examined, they were nonetheless only a small proportion of the children who passed through Nazareth Lodge. In criticising the abuse and unacceptable practices, the good work done by many of the nuns who dedicated their lives to caring for children in difficult circumstances should not be overlooked.

Summary of Findings

363 The following are the findings concerning Nazareth Lodge.

(a) By the 1980s the bathing system used at Nazareth Lodge should have been abandoned long before and its continuation represented systemic abuse.

(b) When Jeyes fluid was first developed in the late nineteenth century it was used for many purposes, but by the 1950s it should not have been used in baths or for hair washing. This practice was well out of date and in our view its use amounted to systemic abuse.

(c) There was no justification for SR 118's cruel conduct in dealing with enuretic boys, which amounted to systemic abuse.

(d) We accept that force-feeding took place and it constituted systemic abuse.

(e) We consider the Sisters' failure to pass relevant information about a child's time in Nazareth Lodge, even if little was known about their lives before coming into the care of the Sisters of Nazareth, was unacceptable and showed a lack of care and consideration for each child's individuality, development and well-being which we considered amounted to a systemic failing.

(f) Taking account of all the aspects of daily life in the home, for the most part they constituted poor, out of date childcare practice, and we consider this was systemic abuse. (Para. 164)

(g) The physical abuse by staff, particularly on the part of SR 118, SR 34, NL 4 and NL 5, was so extensive that it created a punitive atmosphere. It was contrary to good childcare practice, the policy of the Order and the statutory Regulations under which the home worked. Furthermore the Sisters failed to apply a system of staff selection, supervision and management to prevent or limit the abuse. This was a case of systemic abuse and systemic failure.

(h) The name-calling, denigration of parents, lack of care for sick boys, the emotional impact of physical punishment, and the lack of individual care in these examples all constitute emotional abuse as well as unacceptably poor child care practice, and we consider them to have been systemic abuse.

(i) It was the use of charge boys to supervise younger boys in the absence of the sisters which predictably led to the most serious bullying. To rely on the older boys to control the younger ones unsupervised was a systemic failing.

(j) In leaving the care and control of the younger boys to the older charge hands, the opportunities for sexual abuse were increased, and this amounted to systemic abuse.

(k) We agree with the conclusion of the Hughes Inquiry that the frequency of inspection was unsatisfactory and consider the lack of inspection of Nazareth Lodge in that period amounted

to a systemic failing by SWAG to ensure the home was meeting statutory regulations and providing proper care.

(l) It is our view that in this instance the Department failed to accept its overarching responsibility for ensuring that the safety of children in residential care was maintained. We consider that this was a systemic failing.

(m) We acknowledge that the Department was breaking new ground in drafting the Complaints Procedure at this time but we are critical of the Department for this aspect of its policy and of the Sisters for conducting the inquiry secretively.

(n) We conclude that the shortage of finance and its consequent impact on staffing levels and physical standards of care amounted to a form of neglect and constituted systemic abuse. Although both central government and the welfare authorities bore some responsibility, this was primarily the responsibility of the Sisters of Nazareth.

Chapter 10:

Module 6 – Father Brendan Smyth

Introduction

1 John Gerard Smyth joined the Norbertine Order as a novice in 1945, and took the name Brendan, and so he was known as Fr Brendan Smyth for the remainder of his life. He was ordained a priest in 1951 and remained a priest until his death in 1997 while in prison in the Republic of Ireland. Until he was arrested and sentenced in Northern Ireland in 1994 he committed acts of sexual abuse against an unknown number of children in Northern Ireland, in the Republic of Ireland and elsewhere. Although he was convicted of 43 separate offences against 21 children in Northern Ireland for offences committed between 1964 and 1984, and a further 74 separate offences committed against another twenty children in the Republic of Ireland for offences committed there between 1967 and 1993, he admitted on a number of occasions that he did not know how many children he had abused, saying that it could be hundreds.

2 Although granted bail when he was charged in 1991, he was able to leave the jurisdiction and remain at large until he returned to Northern Ireland for trial in 1994 when he pleaded guilty and was sentenced. The Inquiry has not examined why he was able to leave Northern Ireland as that is not within our Terms of Reference. Amongst the 43 offences in Northern Ireland to which he pleaded guilty in 1994 and 1995 for which he was sentenced to a total of four years imprisonment, three related to children who were in Nazareth House in Belfast, and five related to children in Nazareth Lodge, also in Belfast, both of which were children's homes run by the Sisters of Nazareth. However we accept that he also committed offences against other children, some of whom he also abused in either Nazareth House or Nazareth Lodge. He is also alleged to have abused children in two other children's homes in Northern Ireland. One was the home for boys at Rubane, Kircubbin, Co. Down, run by the De La Salle Order, and the other was the home for girls run by the Sisters of St Louis at Middletown, Co. Armagh.

3 It will be evident from the events we describe later in this chapter that Fr Smyth committed offences against many more children, and in many other places, as well as against children who were in those four children's homes in Northern Ireland. Because our Terms of Reference require us to examine whether there were systemic failings on the part of those responsible for children in residential homes in Northern Ireland, our focus has to be on how he was able to commit offences against children in those homes.

4 As Fr Smyth was able to move around and abuse children for so many years, and because the failings of several organisations and individuals contributed to his ability to abuse children over many years in different places, it is necessary for us to consider whether that abuse could have been stopped in those homes in Northern Ireland. The events surrounding his abuse of children in different places over many years are so inextricably interlinked that it is impossible to isolate what happened in the four homes in Northern Ireland within our Terms of Reference from the wider picture of his offending outside those homes, and the failures to protect children from him.

5 For that reason it is necessary to refer in some detail to allegations of abuse of children by Fr Smyth elsewhere, and to consider the response of various organisations and individuals to those allegations. We are aware that Fr Smyth is alleged to have abused children in schools, in the homes of their parents, on visits to Dublin, and in places as far apart as Wales, Scotland and the United States of America. We have to refer to those allegations in order to see when those organisations and individuals were aware of the threat he posed to boys and girls with whom he came in contact as a priest, and to examine what those organisations or individuals did, or did not do, as a result of this knowledge. It may seem to some of those who were abused by him on those occasions that we should have devoted more attention to those allegations, but were we to examine those other allegations in detail that would exceed our Terms of Reference. Nevertheless, by confining our investigation into his activities in this way it should not be thought that we do not appreciate the effect of his activities on those children who do not come within our Terms of Reference, or the implications for organisations or individuals in other countries outside our Terms of Reference.

6 Because Fr Smyth's activities extended over more than four decades it is convenient to consider events in a broadly chronological way before turning to consider the implications of these matters as they relate to the institution or individual concerned. However, because of the unusual structure of the Norbertine Order, and the relevance of that structure to matters which we consider, it is convenient first to examine the structures and processes of the Norbertine Order.

The Norbertine Order

7 The Canons Regular of Premontre are a group of Roman Catholic priests, brothers and sisters who are also known as the Premonstratensians, or White Canons, or as Norbertines after their founder St Norbert. They commonly refer to themselves as Norbertines and were so referred to in the evidence in this module, and we shall therefore refer to them as the Norbertine Order. Norbertines lead communal lives in priories and abbeys under the Rule of St Augustine. Each abbey is a separate community of priests, brothers or sisters, and the Order has a presence in many countries throughout Europe. It also is present in Russia, the United States of America, Canada, South Africa, the Democratic Republic of the Congo, Brazil, Peru, India and Australia. Whilst all members of the Norbertine Order follow a common rule, and are governed by a common code known as the Constitutions of the Premonstratensian Order, nevertheless the individual abbeys or canonries had been described to us by Fr William Fitzgerald of the Norbertine Order as having a semi-autonomous relationship with other canonries so that they resemble a confederation of semi-autonomous communities. Whilst this may be how they regard themselves, it appears to us that in many ways each community was virtually autonomous from the others. This may be contrasted with those orders which have a more centralised and centrally controlled structure such as the Society of Jesus (Jesuits).

8 As it was described in the statement of Fr William Fitzgerald, who is the Prelate Administrator of Holy Trinity Abbey, Kilnacrott, Ballyjamesduff, Co. Cavan in the Republic of Ireland, each abbey or independent priory is a self-standing unit; the term "Order", referring simply to the fraternal union of all of the independent houses of the Order.[1] The Order is presided over by an Abbot General elected by the General Chapter of the Order. We do not propose to refer in detail to the Constitutions of the Order which are to be found in the evidence bundle for this module at FBS 1032 and following. However, a number of observations about the governance and structure of the Order are relevant to the issues that we have to consider. We are grateful to Fr Fitzgerald for his clear exposition of the constitutional and organisational structures of the Order, and in his capacity as Prelate Administrator of Holy Trinity Abbey, Kilnacroft, for his frank and forthright evidence to the Inquiry.

1 FBS 821.

9 Although the Abbot General is described in the Constitutions as the person who "governs the entire Order as the supreme moderator",[2] and is the immediate superior of the governing prelates of the Order, it appears that he has relatively little direct power or authority over the governing prelates, because the Constitutions provide that:

> "He has the right of precept only in the case of visitation, recourse and appeal or as often as the matter concerned comes under his competence."[3]

The central authority of the Order is the General Chapter which meets every six years. It elects four Definitors of the Order who serve as councillors of the Abbot General.

10 Each independent house or community is a self-governing unit, presided over by a prelate usually referred to as the abbot. Within each abbey the abbot, although the head of the community, acts in conjunction with an elected council. It appears to have been the position in the Kilnacrott Abbey at any rate that the collective view of the community of priests could override the view of the abbot.

11 The Constitutions of the Order make provision for the elections of officers known as visitators, whose function it is to carry out visitations or inspections of each house of the Order. Amongst the obligations of the visitators is to carefully examine the meetings of the prelate's council and to accurately report the general condition of the visited house. By reason of his office, the Abbot General is also entitled to undertake a regular visitation in any canonry or house of the Order.[4]

12 Norbertines are bound by vows of stability within their own canonry, and the usual vows of poverty, celibacy and obedience, and are dedicated to the dignified and public celebration of the Eucharist and the Liturgy of the Divine Office each day. In addition, they serve the needs of their Abbey or Priory in varying ways. It appears that may be one of the reasons the Kilnacrott Abbey, of which Fr Smyth was a member, was invited by the then bishop to come to the diocese. The evidence before us suggested that priests from the Abbey were regularly available to assist in the local diocese of Kilmore, or elsewhere, by helping in a supply capacity, such as covering for absences of local priests on holiday, or because of illness, or who

2 FBS 1093.
3 FBS 1093.
4 FBS 1098.

were unavailable for some other reason. This could be done in a number of ways, such as acting as a hospital chaplain for a period, or by simply making informal and personal arrangements between a Norbertine priest and another priest who asked him to help in some capacity. However, this could only take place if the bishop of the diocese gave his permission to a Norbertine priest to preach and administer the sacraments in the diocese, a procedure known as conferring faculties on the priest concerned. We refer to the significance of this procedure for Fr Smyth later. It was also common for priests from the abbey to be sent to serve as parish priests in various parts of the world. Thus at various times Fr Smyth served as a parish priest in Wales, in Scotland, in Rhode Island and in North Dakota, both in the United States of America. Throughout the Order generally, Norbertines have also served as teachers.

Fr Brendan Smyth's Education and Studies for the Priesthood

13 John Gerard Smyth was born in Belfast on 8 June 1927. He was brought up in West Belfast and completed his secondary education in 1945 when he passed his Senior Certificate. It would seem from his results that he was an able pupil, obtaining credits in four of the six subjects, and distinctions in his two remaining subjects, English and Modern History. He joined the Norbertine Order as a novice in Kilnacrott Abbey, Co. Cavan later that summer. His intellectual ability appears to have marked him out as a particularly promising student because he was the first student from Kilnacrott Abbey to be sent to study in Rome. A letter written in September 1949 described him as having a "brilliant mind. Studies well and understands." However, it is abundantly clear that very soon afterwards serious doubts were expressed by responsible members of the Norbertine Order as to his suitability to be ordained to the priesthood. At this time Kilnacrott was not an independent abbey, but was a Priory dependent upon, and subject to, the abbey of Tongerlo, until Kilnacrott became a fully independent canonry and abbey in its own right in 1954.

14 Fr Hermans, the novice master responsible for Brendan Smyth in Kilnacrott at the time, wrote to his superior, the Abbot of Tongerlo in Belgium, conveying the view of Mgr. De Generaal, the Abbot General that:

> "Brendan is very independent and goes his own roads, which is also the case when he goes out. He and [another member of the Order] are the two elements who don't fit in the Communiuteit".

In the letter dated 27 April 1951 Fr Hermans asked:

> "now we are faced with the serious question: can he be ordained in this state?"[5]

15 The correspondence appears to suggest that the concern about Brendan Smyth's suitability to be ordained to the priesthood related to his inability to subordinate his character to the level of obedience required from priests of the Order. On 20 May 1951 Brendan Smyth wrote to the abbot of Tongerlo stating that:

> "at the same time I will pray that I may never fail to profess that sincere filial loyalty and obedience which we all owe to you as our Father and our Abbot."[6]

Despite the strongly-worded advice of the Abbot General that Brendan Smyth was unsuitable for ordination, as the Abbot of Tongerlo was independent he was free to, and did, ignore that advice. He put him forward for ordination to the priesthood, and it would appear that Brendan Smyth was ordained priest by the Archbishop of Dublin, Archbishop John Charles McQuaid, on 31 July 1951.[7]

16 It is clear that there remained significant doubts about his willingness to submit to the requirements of his Order notwithstanding his ordination in July, because on 4 October 1951 Abbot Stalmans of Tonglero wrote a letter to the prior at Kilnacrott instructing him that "if Brendan doesn't commit completely, he isn't allowed to return to Rome",[8] and Fr Smyth was required to make a written promise to that effect. A letter to Fr Smyth from Abbot Stalmans at that time pulled no punches, saying that it seemed he could not accept the views of his superiors and "it seems also that you will take more freedom in relations with the people". Fr Smyth was told that "it is lost money and time to send you back to Rome" unless he was prepared to sign a written promise "that you are prepared to obey completely every Superior in the future."[9] Fr Smyth duly gave the required undertaking, writing on 9 October 1951 that he promised:

> "To live peacefully in the Kilnacrott community, in complete submission to its present Superior and to his successors; I also promise to keep all the Rules and Regulations proper to the Order and to the House as

5 FBS 1012.
6 FBS 1013-1014.
7 FBS 888.
8 FBS 1017.
9 FBS 1019.

> determined and explained by the Superior; finally I promise to accept whatever duties should be given to me to fulfil and I pledge myself to carry them out to the best of my abilities."

17 Pausing at this point, it is clear from the events leading up to and following his ordination that at the very least there were severe doubts as to the suitability of Fr Smyth to be ordained to the priesthood. It would seem, on the basis of the material so far referred to, that these concerns rested on his unwillingness to accept direction and subordinate his views to the requests and requirements of his superiors and the Order. That in itself was highly significant, and we shall see that in later years on many occasions he defied directions and instructions given to him by his superiors, or manipulated them in such a way as to behave as he pleased. We are satisfied that he was a powerful and headstrong character, as well as being intellectually able. He was also a forceful personality who did not hesitate to raise his voice to his fellow priests to intimidate them. Fr William Fitzgerald described how he was a difficult man to handle:

> "...they used to joke down there saying he was the Ian Paisley of Catholic Ireland. You know he had a huge, loud, roaring voice, you know, and all he had to do was yell at someone and they would nearly jump out of their skin."

Fr Fitzgerald also described how on one occasion:

> "...at the end of the Chapter [Abbot Kevin Smith] said to me, 'Oh, that was wonderful'. He said, 'You know, you should have been here for years to pull Brendan into place'. I said, 'Why didn't you do it?' He said, 'I couldn't do it', he said. 'He'd roar me out the door'".[10]

18 However, there is some reason to believe that it may have been known to his superiors at the time that he was wholly unsuitable for the priesthood because of the sexual proclivities which were to become apparent in later years. Fr William Fitzgerald informed the Inquiry that in 1973 he was told by a confrere (brother priest) that a complaint had been made that Fr Smyth had abused a child in the vicinity of the college of the Order in Rome, and that photographs of boys had been found in Smyth's room. It was suggested in 1973 that was the reason why the Abbot General advised against Fr Smyth's ordination. In 1994 Fr Smyth underwent a comprehensive assessment carried out by Fr David Fitzgerald, the programme director of Our Lady of Victory, an institution in Stroud in

10 Day 132, 24 June 2015, p.45.

Gloucestershire run by the Servants of the Paraclete, a Roman Catholic religious order. Although Fr Smyth told him that he first began molesting children shortly after his ordination in the mid-50s,[11] elsewhere in the report there were indications that he was engaging in inappropriate behaviour with a likely sexual origin whilst he was a young religious, saying he disciplined altar boys by spanking them across his knee and sometimes taking down their pants, something that would suggest that he was engaging in this behaviour prior to his ordination. Twenty years earlier on 22 February 1974 during a period of assessment at St Patrick's Hospital in Dublin it was recorded under the heading psychiatric history:

> "Psychosexual difficulties for many years. First developed in the Novitiate."[12]

The reference to his paedophilia first developing in the Novitiate, ie before he was ordained in 1951, lends considerable support to the rumour which Fr Fitzgerald heard in 1973 about Fr Smyth's abuse of a boy in Rome before he was ordained. It is therefore possible that the concerns we have already quoted about his suitability for ordination may have been due, at least in part, to known sexual misconduct, as well as to his unwillingness to obey the rules of the Order.

19 In this context we have taken into account that a minute of an abbot's council at Kilnacrott of 12 April 1994 contained an entry that "Fr Cross, Manchester, had voiced his opinion that B. G. S. was unsuitable for the priesthood". Fr Cross was a member of the Norbertine Order and for many years served as parish priest and house superior of the Order's priory in Manchester. Fr Fitzgerald told us that Fr Cross was a highly respected member of the Norbertine Order, and whilst it is not possible to establish whether Fr Cross's opinion that Fr Smyth was unsuitable for the priesthood was expressed before or after Fr Smyth's ordination, nonetheless it is of some significance. This is because both Manchester and Kilnacrott were subordinate to the abbey at Tongerlo until Kilnacrott became an independent canonry in 1954. There was likely to be a much wider knowledge amongst some senior members of the Norbertine Order because of their common connection with Tongerlo that even then Smyth was thought to have sexually interfered with children, although the lack of more detailed information makes it difficult for us to be satisfied of this.

11 FBS 911.
12 FBS 10653.

20 **In view of the matters we have so far referred to, we are satisfied that the Norbertine Order was guilty of a systemic failing in putting Fr Smyth forward for ordination as a priest despite a clear warning from the Abbot General to the abbot at Tongerlo (who was responsible for putting forward Fr Smyth for ordination) that he was unsuitable.** Whether his unsuitability was due to personality clashes on his part, indicating persistent and significant insubordination to his superiors, or because he had been involved sexually with a younger person in Rome, or both, he was completely unsuited to being trusted with the privileges of a priest. Either he would not obey the rules (including obedience) he had undertaken to observe, or there was already evidence that he was prone to sexual misconduct, or both.

21 That Abbot Stalmans of Tongerlo wrote to Fr Smyth in such scathing terms on 4 October 1951, and felt compelled to extract a written promise from him of future obedience to his superiors such a short time after Fr Smyth's ordination, might suggest that Abbot Stalmans regretted disregarding the opposition of the Abbot General to Fr Smyth's ordination. The Abbot remarked "that [the abbot] was inclined to believe that opinion of the Abbot General about [Fr Smyth's] spirit [was] the truth", and that it was "lost money and time to send [Fr Smyth] back to Rome",[13] remarks which we consider strongly suggested that Abbot Stalmans now recognised that Fr Smyth's insubordination was a significant problem for the Norbertine Order.

22 It may also be significant that Fr Fitzgerald told us[14] that an unidentified confrere (fellow priest) of the Kilnacrott Canonry and Fr Smyth were about to commence their journey to Rome when the prior of Kilnacrott, Fr D'Hoine, arrived and told Fr Smyth that he needed to speak to him, whereupon Fr Smyth disembarked and left his confrere to travel to Rome without him. At that time the prior was the effective head of Kilnacrott, and that he appears to have gone to Dun Laoghaire and removed Fr Smyth from the boat, thereby delaying Fr Smyth's journey to Rome for a few days, was hardly coincidental in view of the correspondence between Abbot Stalmans and Fr Smyth referred to earlier. However, as nothing more is known of that event we do not feel that we can attach any further significance to it.

13 FBS 825, 1017-1019.
14 FBS 826.

1951 to 1965

23 The only information given to the Inquiry about Fr Smyth's conduct during the period immediately following his ordination in 1951 is that we were informed by Mason Hayes & Curran, solicitors for the Norbertine Order, that they were aware of a complaint made by a father and his son to Kilnaleck Garda station in Co. Cavan as far back as about 1952.

24 When Kilnacrott Priory became an independent canonry in 1954, Fr Felim Colwell was appointed abbot and held that position until his death in 1968. Fr Smyth appears to have continued his ministry at Kilnacrott Abbey until 1957 when Abbot Colwell sent him to Annan in Dumfries, in Scotland. Information provided to the Inquiry by the Bishop of Galloway indicates that Fr Smyth served as an assistant priest in Annan for a short period between August 1957 and January 1958, and then returned to Kilnacrott.[15] [16] Neither the Norbertine Order nor the Diocese of Galloway has any other documentary information relating to his period there.

25 However, Fr Fitzgerald told the Inquiry that a confrere who had worked in Scotland between 1969 and 1987 recalled rumours that Fr Smyth had been deprived of his ecclesiastical faculties when he was in Scotland. If his priestly functions were restricted at that time, that would suggest that Fr Smyth transgressed in a substantial way during his time in Scotland. Fr Fitzgerald said that there was a suggestion of interference with children at that time. That accords with the statement of Fr Bruno Mulvihill[17] to which we refer later. It also is consistent with the admission by Fr Smyth to Fr David Fitzgerald in Stroud in 1994 that "I first began molesting children shortly after my ordination in the mid-1950s",[18] and therefore it is entirely possible that he abused a child or children in Scotland in 1957 or 1958 as was rumoured, although it is not possible to put the matter any more definitely than that.

26 Whatever may have led to his recall from Scotland, almost immediately Fr Smyth was sent to North Wales, which at that time was part of the Diocese of Menevia, but with the creation of a new Diocese of Wrexham in 1987 is now part of the Diocese of Wrexham.[19] He served in that diocese from

15 This information was requested by the Inquiry, and provided by the Bishop of Galloway, after the public hearings in Module 6.
16 FBS 1287.
17 FBS 32124.
18 FBS 911.
19 (www.dioceseofmenevia.org/home/the-history accessed 8 July 2015).

late February 1958 until June 1963, and from June 1958 until June 1963 he served in Flint.[20] [21] Documents provided to the Inquiry by the Bishop of Wrexham suggest that in January 1962 Fr Smyth was the subject of allegations that he struck a boy, put his hand up the boy's shirt, took the boy on his knee and detained the boy on his own. A brief handwritten note records that Fr Smyth denied the allegations. Presumably his denials were accepted because he continued his ministry in Flint until June 1963.[22]

27 The Bishop of Wrexham also provided the Inquiry with a letter from FBS 55, and a clipping from a newspaper interview in which he described how, as a small boy, he was taken on a trip to Kilnacrott by Fr Smyth during which they stayed in the Gresham Hotel in Dublin. In the letter FBS 55 described how devout his parents were, and in the article he described how Fr Smyth wheedled his way into the affections of children in a manner that echoed the testimony of several victims examined by the Inquiry. Having described how Fr Smyth was friendly with the altar boys:

> "He would tweak our ears and while he was hugging you he would pass you a tube of sweets. As a child of that age brought up in a very Catholic environment I was in awe of him."[23]

28 The documents provided by the Bishop of Wrexham reveal that in 1963 Fr Smyth was sent back to Ireland from Wales because he had sexually abused an altar boy there (probably FBS 55). The Bishop of Menevia wrote to Abbot Colwell at Kilnacrott on 7 June 1963 to say that Fr Smyth had admitted allegations by a boy of ten that Smyth had encouraged the boy "to commit indecent actions", and that in those circumstances he was being sent back to Kilnacrott. Ironically the bishop commented:

> "…evidently this is a weakness in his character which I feel sure must have been completely unknown to you."[24]

Rhode Island 1965 to 1968

29 Whatever denials Fr Smyth may have put forward in the past if he were challenged about the rumours the Inquiry has been told were current before 1963, the letter from the Bishop of Menevia to Abbot Colwell

20 This information was requested by the Inquiry, and provided by the Bishop of Wrexham, after the public hearings in Module 6.
21 FBS 1245.
22 FBS 1257.
23 FBS 1268.
24 FBS 1259.

stated that Fr Smyth had admitted contact with a child in circumstances that displayed an unmistakably sexual motivation on his part. Clearly Fr Smyth had been sent back to Kilnacrott in disgrace. However, subject to the evidence about the decree or rescript from the Vatican described by the late Fr Bruno Mulvihill to which we shall refer later, there is nothing to suggest that Abbot Colwell took any steps at that time to restrict Fr Smyth's activities, or to ensure that he would not be in a position where he could exploit his position as a priest to engage in such behaviour again. In particular, nothing appears to have been done to prevent him from having unsupervised access to children, such as hearing confessions, or stopping him being alone with altar boys or children in the Abbey choir. It would also appear that he was able to move around freely inside and away from the Abbey. **We consider that the failure of Abbot Colwell to take such steps represents a systemic failing on the part of the Norbertine Order.**

30 Given that Bishop Petit of Menevia had referred to the "weakness in his character" it is astonishing that Abbot Colwell felt able to send Fr Smyth to another diocese when Fr Smyth was assigned by Kilnacrott Abbey to the Diocese of Providence, Rhode Island in the United States of America in 1965. There is nothing to suggest that Abbot Colwell gave any warning to the bishop of that diocese about Fr Smyth's behaviour in Flint. Indeed it seems that the bishop was not told. When Abbot Kevin Smith, (no relation to Fr Brendan Smyth), wrote to a journalist[25] on 26 September 1994, he said of both occasions when Fr Smyth was sent on temporary assignment to the USA "on neither occasion was the Bishop of the Diocese to which he was sent notified of his propensity to molest children".[26]

The first such occasion was when Fr Smyth was sent to the Diocese of Providence and, as we shall see, he was sent later to the Diocese of Fargo in North Dakota.

31 By February 1965 at the latest, Abbot Colwell knew enough about Fr Smyth's behaviour for it to be imperative for the abbot:

(1) to warn the Bishop of Providence that Fr Smyth was a danger to children, and not send him to Rhode Island;

(2) to confine him within the Abbey premises at Kilnacrott;

25 Chris Moore, whose book *Betrayal of Trust: The Fr Brendan Smyth Affair and the Catholic Church* contains much valuable information on Fr Smyth's actions.

26 FBS 976.

(3) to prevent him from having any unsupervised contact with children in Kilnacrott itself;

(4) to report his sexual behaviour to the police and to social services; and

(5) to institute the necessary steps to have him removed from the priesthood.

The failure to warn the bishop of the diocese to which Fr Smyth was being sent of Fr Smyth's behaviour in Flint can only be explained as a deliberate policy on the part of Abbot Colwell to keep this information back from the Bishop of Providence. By doing so he undoubtedly exposed the children of that diocese to the risk of sexual abuse by Fr Smyth. On 15 February 1968 Bishop McVinney wrote to Abbot Colwell, explaining that whilst Fr Smyth's "rapport with the adult parishioners", was not good, "he seemed dedicated to the young people, and in some cases too much".[27] Fr Fitzgerald informed us that the Kilnacrott canonry has since been informed of five cases of child sexual abuse allegedly perpetrated by Fr Smyth during his time in Providence, and that strongly suggests the comment that Fr Smyth was sometimes too dedicated to young people was a careful way of saying that he had transgressed in some way.

The Events of 1968

32 We are satisfied that at the time of Fr Smyth's return to Northern Ireland in 1968 his behaviour in Rhode Island was known by Abbot Colwell. In 1994 Fr Smyth told Fr David Fitzgerald that while he was in East Greenwich in Rhode Island, "there were immodest touches, not real sexual abuse", and that he had been reported to the bishop "for touching an eleven year old altar boy". Fr Smyth went on to say that he: "told my Superior about these incidents in East Greenwich between 1965 and 1968 because I thought the Bishop there would have told my Superior".[28]

33 In addition, there is evidence that Abbot Colwell was not surprised by the news from Rhode Island. In 1995 Fr Mulvihill made a statement to the RUC in which he said that he received a phone call from the Bishop of Providence saying that Fr Smyth had been dismissed because of a sexual misdemeanour and was on his way back to Ireland.[29]

27 FBS 938.
28 FBS 912.
29 FBS 32124.

Fr Mulvihill alleged that when he went to see Abbot Colwell in hospital, accompanied by Prior Nash, the Abbot was:

> "Obviously disappointed but not altogether surprised told us that this had been the third time Fr Brendan had been involved in sexual deviant activities. The first time was in Annan, the Diocese of Galloway, Scotland, the second time being in North Wales in the Diocese of Menevia in the County of Gwynedd".

Although some members of the Norbertine Order take issue with much of what Fr Mulvihill, who died in a car crash in Germany in 2004 aged 59, has to say about events relating to Fr Smyth at Kilnacrott, the account he gives is supported by the account given by Fr Smyth to Fr David Fitzgerald already referred to.

Fr Mulvihill's Allegations

34 In the statement he made to the RUC on 14 March 1995, Fr Mulvihill described how in 1968 he was cleaning a vacant room in Kilnacrott, which had been formerly occupied by Fr Smyth, when he found a copy of a decree (or rescript as it has been described elsewhere)[30] issued by the Congregation of Religious and for Secular Institutes relating to Fr Smyth. As Abbot Colwell died on 24 September 1968 and his successor Abbot Kevin Smith was not elected abbot until 12 June 1969, the senior cleric at Kilnacrott Abbey at the time was the prior. As the prior was out that day Fr Mulvihill said he handed the copy to the sub-prior, who assured him that he had placed the copy on Fr Smyth's file. According to Fr Mulvihill the decree was dated after Fr Smyth's return from Providence Rhode Island, i.e. after January 1968. The decree stipulated that Fr Smyth was only to leave the precincts of Kilnacrott Abbey with permission, and never alone, and that his faculties for confession (that is his authority to hear confessions) were withdrawn for the rest of his life. Fr Mulvihill went on to allege that sometime later when he was serving in Germany but returned to Kilnacrott for visits he saw Fr Smyth behaving as if the decree did not exist; he was hearing confessions and leaving the Abbey in his own car. Fr Mulvihill claimed that he approached Abbot Smith about this:

> "Only to be told that in his opinion Fr Brendan had been penalised sufficiently that there was no possibility of further misdemeanour and in any case the stipulations of the Decree were far too stringent".[31]

30 FBS 987.
31 FBS 32125.

35 These allegations by Fr Mulvihill are significant for at least two reasons. The first is that in 1968 the Congregation of Religious and for Secular Institutes in Rome, (since renamed the Congregation for the Institutes of the Consecrated Life and for Societies of Apostolic Life) was the Vatican body responsible for the discipline of those such as Smyth who were members of Roman Catholic religious orders.[32] If a decree such as that described by Fr Mulvihill was issued concerning Fr Smyth then that implies formal ecclesiastical disciplinary proceedings were instituted against Fr Smyth, and as a result he was placed under strict limitations designed to prevent him being in unsupervised contact with children. As Fr Smyth apparently admitted to his superior, that is Abbot Colwell, what he had done in Rhode Island, and given that the abbot had been told by the Bishop of Menevia of Fr Smyth's admissions to the complaint by the parents of the altar boy in Flint, then it would seem that the obvious person to institute such ecclesiastical proceedings against Fr Smyth would have been Abbot Colwell as Fr Smyth's superior. Not only that, but Fr Mulvihill asserted that such a decree would have been transmitted to Kilnacrott via the Abbot General, meaning that the Norbertine Order as well as the Abbey at Kilnacrott were well aware of the existence and terms of the decree. Fr Mulvihill believed that the decree was issued because of the complaint in America, by which he presumably meant the allegation about Fr Smyth's behaviour in the Diocese of Providence, Rhode Island, that resulted in his being sent back to Ireland at the beginning of 1968.

36 The second reason why the decree would be significant is because the freedom of movement exercised for many years thereafter by Fr Smyth, and his hearing confessions for many years, could only have happened because both he and his superiors in Kilnacrott chose to ignore the decree, or the decree expired, or had been modified or revoked. Fr Mulvihill alleged that when he raised his concerns with Abbot Kevin Smith, the abbot told him, "that in [Abbot Smith's] opinion Fr Brendan had been penalised sufficiently". If Abbot Kevin Smith reacted as Fr Mulvihill described, then the failure of the Norbertine Order and Abbot Kevin Smith to ensure that Smyth was not allowed to leave Kilnacrott Abbey unsupervised, and was allowed to hear confessions, would amount to systemic failings by the Order and Abbot Kevin Smith. Fr Kevin Smith is no longer abbot and was invited to assist the Inquiry. Although he initially declined to do so, he later

32 See: www.vatican.va/romancuria/congregations/cccscrlife/documents/rc con cccsr life profile, accessed 14 July 2015.

informed the Inquiry by letter that he had no knowledge of the existence of such a decree, nor did he make such a comment as related above.

37 Efforts have been made by the Norbertine Order to establish whether a decree such as that described by Fr Mulvihill ever existed. Fr William Fitzgerald said that there is no record of such a decree in the files of the Abbot General, and that in 1995 no one in Kilnacrott had any recollection of such a document.[33] In 1995,[34] and again in 2007,[35] the Congregation for the Institutes of Consecrated Life and Societies of Apostolic Life confirmed that there was no trace of such a document in its archives, nor had the Bishop of Kilmore any record of such a document.[36]

38 Fr Mulvihill also alleged to the RUC that he expressed his concerns about what he termed Fr Smyth's "irregularities" to both Bishop McKiernan of Kilmore and to Archbishop Alibrandi, then the papal nuncio (the Vatican ambassador to the Republic of Ireland and liaison between the Irish Bishops Conference and the Vatican) in 1974, but received no satisfaction from either.

39 There is some further evidence that tends to support Fr Mulvihill's recollection of there being a decree or rescript, because Fr William Fitzgerald related an incident recounted to him by a confrere that occurred in 1968. Abbot Colwell died in 1968 after Fr Smyth was sent back from the Diocese of Providence earlier in the year, and the confrere recounted to Fr Fitzgerald how Abbot Colwell said to him:

> "He [Fr Smyth] can't hear confession. He can't say mass. He can't preach. He can't leave the abbey grounds except in the company of another priest and that's because he fiddled about with children in Rome".[37]

Although this is hearsay, and the reference to Rome possibly a mistake for Rhode Island, nevertheless Fr Fitzgerald impressed us as a conscientious and forthright witness. If the confrere's recollection was correct then that would suggest that either Abbot Colwell imposed such sanctions on Fr Smyth on his own authority, or in response to a decision from the Vatican, which may have taken the form of a decree as described by Fr Mulvihill. Another possibility is that Abbot Colwell imposed the sanctions, which were then confirmed by a decree from the Vatican.

33 FBS 978.
34 FBS 979.
35 FBS 989.
36 FBS 981.
37 Day 132, 24 June 2015, p.35.

40 As the Vatican authorities have stated that no trace of such a document can be found in their archives, and as Fr Mulvihill died in 2004 and Archbishop Alibrandi and Bishop McKiernan have also died, we are unable to reach a firm conclusion on the conflict between the accounts of Fr Mulvihill on the one side and the absence of any documentary evidence, or evidence from any of those to whom Fr Mulvihill referred, other than the evidence of Fr Kevin Smith referred to above.

Treatment at Purdysburn Hospital 1968 to 1969

41 It would appear that after Fr Smyth was sent back to Kilnacrott in January 1968 Abbot Colwell arranged for him to have some form of treatment. In his letter of 26 September 1994 to the Ulster Television journalist Chris Moore, Abbot Kevin Smith said, "In 1968 we sought treatment for Fr Smyth in Purdysburn Hospital in Belfast". It appears that this took the form of outpatient appointments with Dr J. W. Patten, a principal clinical psychologist at Purdysburn Hospital on the outskirts of Belfast. Unfortunately the hospital file relating to Fr Smyth does not contain any summary, reports or notes of the consultation, only some appointment correspondence and three psychometric tests which appear to have been performed in April 1968. The appointment correspondence would suggest that the appointments started in April 1968 and continued on an outpatient basis until at least 29 May 1969. In his letter to Chris Moore Abbot Smith said "aversion techniques were used", but other than a later reference by Fr Smyth to his receiving electric shock treatment,[38] there is no other material that casts any light upon the nature of the treatment.

42 This was the first of several unsuccessful attempts by the Norbertine Order to secure some form of psychological or psychiatric treatment for Fr Smyth. On this occasion there is no record of the Order requiring Fr Smyth to produce a written report to them from Dr Patten on the treatment, or giving his opinion on the success or otherwise of the treatment, and, most importantly of all, what if any precautions should be taken in the future to ensure that Fr Smyth did not continue to pose a danger to children. Notwithstanding the absence of any such information, and despite the by now considerable amount of evidence that Fr Smyth did pose a real danger to children with whom he was able to come in contact, and even though it was the Norbertine Order that had arranged for him to undergo

38 FBS 913.

this treatment, it would seem that the Order allowed him to continue to perform his clerical duties throughout the period of his treatment without subjecting him to any restraint or supervision. That would appear to be the case to judge by a request made by Fr Smyth in a letter to Dr Patten of 27 April 1969 to rearrange the date of an appointment because Fr Smyth was going to conduct a school retreat in Co. Longford in early May 1969 lasting from Monday to Friday. **We regard the failure of the Order to impose any restraints on Fr Smyth during the time he was receiving treatment, together with the apparent failure of the Order to insist on receiving a diagnosis from Dr Patten as to the safety of permitting Fr Smyth to have any contact with children in the future, as systemic failings on the part of the Order.**

Events of 1969 to 1975

43 In the years following the end of Fr Brendan Smyth's attendance with Dr Patten in 1969 we are satisfied that the Norbertine Order at Kilnacrott was aware from further complaints drawn to their attention that Smyth was continuing to sexually abuse children while he was living in Kilnacrott Abbey. Fr William Fitzgerald stated that Abbot Smith received a complaint (which Fr Fitzgerald places around 1971 or 1972) from a mother that Fr Smyth had sexually abused her son. Fr Fitzgerald's evidence was that although Fr Smyth denied the offence Abbot Smith suspended Fr Smyth from the public performance of his priestly duties for two weeks. Fr Fitzgerald described this penalty as "just baffling" saying that "it should have been for life".[39] It is noteworthy that Abbot Smith disbelieved Fr Smyth's denial of the offence. It is not known whether the offence was committed in the Republic of Ireland or in Northern Ireland, yet Abbot Smith failed to report the allegation to the police and to the social services in whichever jurisdiction the offence had occurred. Nor were any steps taken to confine Fr Smyth to Kilnacrott Abbey, or to prevent him having any contact with children while he was living in the Abbey.

44 Abbot Smith's explanation for these failures in the letter to the UTV Journalist Chris Moore, to which we have already referred, was that:

> "In those years frequent reassignment was often the way church authorities handled priest paedophiles and other problem priests. Fr Smyth was reassigned every few years or so in an effort to keep him

39 Day 132, 24 June 2015, p.55.

from forming attachments to families and their children. We now see how inadequate this approach actually was."[40]

"We always hoped that a combination of treatment, Fr Smyth's intelligence and the grace of God would enable Fr Smyth to overcome his disorder. We did not adequately understand the compulsive nature of his disorder or the serious and enduring damage which his behaviour could cause."[41]

45 That approach was not one that commended itself to other members of the Order at the time, at least to judge by Fr William Fitzgerald's reference to the refusal in 1973 or thereabouts of the headmaster of the school associated with their priory in Australia to contemplate inviting Fr Smyth to come to teach there because a teacher at the school had been dismissed for interfering with a child. As Fr Fitzgerald put it, "(the headmaster) knew about Brendan's proclivities in 1973".[42]

The 1973 Complaint

46 There is a reference in the Kilnacrott Abbey council minutes for May 1973 to another complaint being made.[43] Whilst no other details are given, it is highly likely that this is a reference to a complaint made to FBS 49 of Kilmore Diocese by a mother from the Co. Cavan area. She told them that Fr Smyth had slept with her fourteen-year-old daughter and had sexual intercourse with her during an overnight trip to Dublin. She and her daughter had recently been bereaved, and we believe that she and her daughter would have been grateful for the concern shown by Fr Smyth in taking her daughter away like this. FBS 49 asked her whether she wanted to report the matter to the Garda Siochana (the Irish police) but the mother did not want to do so. However, he reported the matter to Bishop McKiernan[44] who undertook to him to deal with it. There is no record of what action the bishop took, but from the conjunction of events, it seems highly probable that Bishop McKiernan informed Abbot Smith of the allegation, hence the reference in the council minutes. There is no record of the Norbertine Order taking any action on this complaint to

40 FBS 975.
41 FBS 976.
42 Day 132, 24 June 2015, p.32. The priory in Perth, Western Australia was at that time dependent upon Kilnacrott. All the residents, except for Fr Fitzgerald, were Irish.
43 FBS 837.
44 Bishop McKiernan appears to have spelt his name McKiernan or MacKiernan at different times. To avoid confusion we refer to him as Bishop McKiernan throughout.

inform the police or social services of this very serious allegation. Nor did Bishop McKiernan do so, a step which we consider that he should have taken, notwithstanding the views of the mother relayed to him by FBS 49, in view of the gravity of the allegations. **We consider these failures of the Norbertine Order in the form of Abbot Kevin Smith and of Bishop McKiernan to be systemic failings on their part.**

Medical Treatment in 1973 and 1974, and the Finglas Episode

47 During the public hearings of this module, the Inquiry was provided with information and documents by Mason, Hayes and Curran, solicitors for the Norbertine Order. This revealed that Fr Smyth underwent psychiatric evaluation and treatment in St Patrick's Hospital, Dublin, under the care of the late Professor JNP Moore, the medical director of the hospital. It would appear that his attendances at St Patrick's Hospital were arranged by the Norbertine Order because Abbot Smith saw Prof Moore on 25 May 1973, although without Fr Smyth's knowledge.[45] Abbot Smith told Prof Moore that Fr Smyth had seduced a twelve year old girl and had sexual intercourse with her. Prof Moore recorded that:

> "Order are now very concerned and anxious to know if anything can be done to help this man and avoid such incidents in the future".

48 Coming as it did very soon after the complaint to FBS 49, and in view of the reference by Prof Moore in his interview of 25 May 1973 with Fr Smyth that Fr Smyth had become attracted to a little girl of eleven when "some fairly elaborate sexual interference short of intercourse took place repeatedly", we are satisfied that the reaction of Abbot Smith to the allegations conveyed by FBS 49 was to arrange for Fr Smyth to undergo a course of treatment. Although the ages of the child referred to vary in these references, we consider it unlikely that different children were being referred to, and consider it more likely that there was some confusion as to the age of the girl when the ages were recorded by different people.

49 From the documents provided to the Inquiry by the Norbertine Order it appears that Fr Smyth's engagement with Prof Moore lasted until at least late February 1974. During that time Fr Smyth was living in Kilnacrott, and attending appointments with Prof Moore, although at some stage he appears to have undergone a period of inpatient treatment. Fr William

45 FBS 10639.

Fitzgerald told the Inquiry that Fr Smyth was an inpatient for approximately three weeks.[46] Prof Moore wrote to Abbot Smith on 28 May 1973 and made several highly significant comments. The first was that Prof Moore did not think there was "any specific treatment likely to enable [Fr Smyth] to achieve a more adult heterosexual orientation". The second was that it should be possible for Fr Smyth "to continue with his work and to give valuable and reliable service to the community", with more insight and understanding and perhaps some chemotherapy. However, these were subject to a third, extremely important, caveat, namely that "wherever he is stationed his Superior should be aware of his difficulties".

50 When Fr Smyth saw Prof Moore again on 15 June 1973 Fr Smyth told Prof Moore that he "has had homosexual relations with a boy of sixteen years on two occasions since", (that is since he had seen Prof Moore on 28 May 1973).[47] Notwithstanding this, and despite Prof Moore's warning to Abbot Smith that wherever Fr Smyth was stationed, "his superior should be aware of his difficulties", by 4 July 1973 Fr Smyth was directing a retreat at Our Lady's Retreat House at Finglas in Dublin.[48] If Fr Smyth were conducting this retreat with the knowledge, and presumably therefore the approval, of Abbot Smith, were the organisers of the retreat made aware of Fr Smyth's predatory and sexual attitude towards children as recommended by Prof Moore? If Fr Smyth were able to conduct this retreat without the approval of Abbot Smith, why did the Abbot not insist on knowing at all times where Fr Smyth was and what he was doing? After all, by now there had been a significant number of allegations against Fr Smyth from many different quarters over several years, at least some of which Fr Smyth had admitted to his superiors, and the Order had arranged for a previous, and obviously unsuccessful, course of treatment for him at Purdysburn Hospital in Belfast less than four years earlier.

51 The Finglas retreat in July 1973 is also relevant because it would seem likely that at some point during his stay in Dublin Fr Smyth committed another sexual offence involving a child. In his letter to Prof Moore of 30 November 1973 Fr Smyth referred to, "the Garda complication". The information available to the Inquiry did not reveal exactly what occurred, but as An Garda Síochána were involved that suggests to us that a complaint of a criminal offence by Fr Smyth had been made to the local

46 FBS 827.
47 FBS 10641.
48 FBS 10642.

Gardaí in Finglas. This conclusion is strengthened because Prof Moore wrote to Abbot Smith on 1 November 1973 referring to Fr Smyth having, "some further difficulties", and recommending that "a period in hospital for further evaluation and treatment" would be appropriate.[49] That this suggestion that a period of inpatient treatment was related to "the Gardaí complication" may be inferred from a letter sent by Prof Moore on 1 November 1973 to a detective at Finglas Garda Station saying that he had been asked to write to the Garda concerned by Smyth. Prof Moore continued:

> "He has been a patient under my care for some months and I am familiar with the nature of his problems. I am writing to his superior suggesting that he should have a period of inpatient care in St Patrick's Hospital or St Edmondsbury convalescent home, as soon as I have a suitable vacancy. I hope this arrangement will be satisfactory to you and your superiors."[50]

52 In his letter to Prof Moore on 30 November 1973 Fr Smyth made it clear that he had not disclosed "the particular Finglas facts" to his superiors, nor did he intend to do so. He says, "They", made a request to which he agreed:

> "Now [w]hen the Garda complication arose only I myself knew about it and the authorities were very insistent that they would not in any way be responsible for anyone even where I lived learning about the problem. They simply made the request you know of and I agreed without any hesitation whatsoever. I was able, in the circumstances, quite truthfully to approach my superiors [to] say that I was unhappy with the way I was getting along with my problem and that I was going to ask you to arrange for me to spend some time in a suitable hospital or nursing home so that I might be able to gain a bit of confidence in dealing with the situation in the future. My superiors were quite happy with my decision and assured me that I had a completely free hand as far as they were concerned. This being so I fail to see how any disclosure of the particular Finglas facts would make it possible for you to deal with the matter more effectively."[51]

53 While Fr Smyth did not identify who "They" were, the tenor of the passage quoted above infers that it may have been members of An Garda Síochána

49 FBS 10645.
50 FBS 10644.
51 FBS 10648.

who made the suggestion that he receive a period of inpatient treatment. If that inference is correct, then that would account for the terms of the letter written by Prof Moore to the Gardaí at Finglas station already referred to. Furthermore, Fr Smyth's account makes clear that he did not reveal to Abbot Smith why it was necessary for him to undergo a period of inpatient treatment. Finally it is clear that Fr Smyth was determined to ensure that the facts relating to whatever the allegation was against him in Finglas would not be disclosed to his superiors. Prof Moore suggested on two occasions to Abbot Smith that they meet in order to discuss the nature of Fr Smyth's condition, but in 1975 Abbot Smith told Bishop McKiernan of Kilmore that when he, Abbot Smith, went to speak to Prof Moore, Prof Moore refused to discuss Fr Smyth's case with him, citing patient confidentiality.[52]

54 As already quoted from an earlier part of the letter, Fr Smyth had decided that he would not permit Prof Moore to disclose these matters to Abbot Smith, pointing out that he was the patient and was paying for the treatment himself.[53] We regard that as significant because it shows that Fr Smyth was able to manipulate the doctor/patient relationship between himself and Prof Moore to his own advantage, and did so to prevent the Order from getting any prognosis about Fr Smyth's future behaviour from Prof Moore. It is noteworthy that on this occasion, as on many other occasions, Fr Smyth had access to funds which enabled him to pay bills, whether for medical care, hotels or other purposes. Given his vow of poverty, we are surprised that his ready access to such funds appears not to have raised any concerns at Kilnacrott. This may not be unconnected with the criticism by Fr Fitzgerald when he described how other Norbertines were surprised at the way in which priests at Kilnacrott had cheque books and cars, things that were not usual for Norbertine Fathers to have.[54]

55 As the letter is addressed from Ward 1, that suggests Fr Smyth appears to have been admitted to St Patrick's Hospital for some weeks for a course of treatment. During that time he underwent psychological testing. He was also treated with Largactil and the final diagnosis made in February 1974 was one of paedophilia,[55] accompanied by the conclusion: "Prognosis: this must remain guarded".[56]

52 FBS 780.
53 FBS 10648.
54 Day 132, 24 June 2015, pp. 76 and 77.
55 FBS 10653.
56 FBS 10654.

56 The account given two years later by Abbot Smith to Bishop McKiernan suggests that Fr Smyth was able to manipulate the process and keep to himself the nature of the diagnosis and prognosis given to him. Given that Fr Smyth wrote to Prof Moore from Ward 1 of St Patrick's Hospital on 30 November saying that he (Fr Smyth) had decided definitely not to accept Prof Moore's suggestion that he explain the full situation to his superior, we accept that Abbot Smith was deliberately kept in the dark by Fr Smyth about the nature of the diagnosis and treatment that the hospital contemplated at that time.

57 We consider that there are a number of steps that the Norbertine Order should have taken once Bishop McKiernan informed them of the allegation made by the mother of the child early in 1973.

(1) This was a serious allegation, and in view of the previous allegations known to the Order, we consider that there was no justification whatever for the Order, and for Abbot Smith as his religious superior, not reporting the allegation against Fr Smyth to An Garda Síochána and to the social services in the Republic of Ireland.

(2) Fr Smyth had been sent for treatment, which the Order appears to have organised, and the Order should have insisted that Fr Smyth waived the doctor/patient confidentiality in his case and authorised Prof Moore to fully disclose to Abbot Smith the nature of Fr Smyth's treatment and the prognosis for the future. Fr Smyth's failure to do so, conveyed to Abbot Smith in the abortive meeting with Prof Moore, ought to have set alarm bells ringing with the Order, and it should have insisted that Fr Smyth reveal the full medical position to them, and if he failed to do so the inevitable conclusion ought to have been that he was hiding something. In that case we consider that in view of the various offences he had admitted the necessary canonical steps should have been put in train by Abbot Kevin Smith, as Fr Smyth's superior, to seek to have Fr Smyth removed from the priesthood.

(3) Given Fr Smyth's by now well-known propensity to commit sexual offences with children he should have been confined to Kilnacrott Abbey and prevented from having any form of unsupervised contact whatever with children in the future, in particular being left alone in a room with them, as for example when hearing confession. He should also have been deprived of the use of his car and the means that gave him to travel about at will. If it was necessary for him to

leave the Abbey at that time for any reason, for example to go to St Patrick's Hospital, he should only have been allowed to do so under the supervision of another member of the Order. **We consider that by failing to take these steps the Norbertine Order was guilty of systemic failings in each of these respects.**

Diocese of Kilmore

58 **We consider that the Diocese of Kilmore was also guilty of systemic failings in the way it dealt with the allegations made to it at that time.**

(1) In view of the gravity of the allegations it should have reported the matter to An Garda Síochána and to the social services in the Republic of Ireland, irrespective of the wishes of the mother of the child.

(2) The diocese should not have left the matter in the hands of the abbot and the Norbertine Order, but should itself have instituted canonical proceedings by notifying the congregation of the Doctrine of the Faith (then known as the Holy Office) as it had jurisdiction to do.[57]

59 We should also record that in his written statement to the Inquiry on behalf of the Diocese Fr Donal Kilduff, Chancellor and Diocesan Secretary to the Diocese of Kilmore, said in relation to the events in 1975 that the Diocese:

> "Would accept that the failure of Bishop McKiernan to report the matter to the civil authorities or to ensure that the matter was reported by Abbot Smith to the civil authorities was a failing on the part of the Bishop."

60 Although this concession was made in relation to the events of 1975, we consider that it applies with equal force to the events of 1973, although it is right to record that when Fr Kilduff was asked why things were not taken to the Gardaí at the time he replied:

> "I think that not only in the 70s. I think throughout for a long time the authorities perhaps weren't – weren't trusted and they were – maybe the process would take too long and some people took things into their own hands, but I think there was that culture of not going to the authorities and maybe it would get lost, you know."

57 FBS 50027.

61 We recognise that there may be issues relating to the way Finglas Garda Station dealt with the allegations made against Fr Smyth in 1973. Whether there was some form of collusive action, either instigated or approved by a member or members of An Garda Síochána stationed at Finglas Garda Station, that resulted in a decision not to prosecute Fr Smyth if he sought medical treatment we are unable to say on the limited evidence available to us. Nevertheless there are clearly matters of a criminal or disciplinary nature relating to what occurred that may require to be investigated. Had these matters occurred in Northern Ireland then we would have followed our usual practice of reporting them to the PSNI. As these matters relate to events in the Republic of Ireland we have drawn them to the attention of the Commissioner of An Garda Síochána for whatever action may be necessary.

The Kilmore Investigation of March and April 1975

62 On or shortly before 29 March 1975 Brendan Boland, a fourteen-year-old boy from Dundalk, Co. Louth in the Republic of Ireland, alleged to FBS 48 that he had been subjected to sexual abuse by Fr Smyth. FBS 48, although a Dominican priest, was acting as a parish priest in Dundalk, and whilst the allegations related to events within that part of the Archdiocese of Armagh that is in Co. Louth, FBS 48 alerted Bishop McKieran of Kilmore, because he was the bishop within whose diocese Fr Smyth lived at Kilnacrott Abbey. Bishop McKiernan immediately instigated an ecclesiastical investigation, which involved three priests. One was FBS 50 who was a curate in Dundalk at the time. Although he was a priest of the Armagh Archdiocese, he was a canon lawyer (that is someone trained in church law) and appears to have been asked to take part in his personal capacity rather than as an official representative of the Archdiocese. The second priest was FBS 48 to whom the allegation had been made. The third was the then Fr John Brady, who at that time was a language teacher at St Patrick's College, Cavan, Co. Cavan. He also had a doctorate in canon law, and from time to time acted as secretary to the bishop. Fr Brady is now Cardinal Brady, Archbishop Emeritus of Armagh, following his retirement as Archbishop of Armagh and Primate of All Ireland in September 2014. Fr Brady was appointed coadjutor Archbishop in 1995.[58] From Cardinal Brady's account it appears that the investigation

58 A coadjutor is a person appointed as a co-holder of a post such as a bishopric to act as assistant to the existing bishop or archbishop, with a view to succeeding to the post of bishop or archbishop when the incumbent retires.

was carried out on an ad hoc basis following a procedure loosely based on that used at the time in Roman Catholic marriage tribunals. FBS 50 asked the questions, and the questions and answers were recorded by Fr Brady. FBS 48 appears to have been present as an observer.

63 The 30 questions and answers can be found at FBS 10009 and so it is unnecessary to set them out in this part of the report. Three aspects of what occurred during that meeting merit criticism.

(1) Although Brendan Boland's father brought him to the interview, his father remained outside the room while his son was being questioned. Brendan Boland was a fourteen-year-old boy left alone in a room with three priests. This should not have happened, and his father should have been in the room with him throughout. In the book which Brendan Boland has since published about his experiences he said:

> "In my mind's eye they were old men in black and, if they made any effort to be non-threatening they failed."

In his evidence to the Inquiry Cardinal Brady accepted that the boy's father should have been present and that he could see now that the situation was intimidating for a fourteen-year-old.[59]

(2) Some of the questions the child was asked were unnecessary and completely inappropriate. For example, having asked the boy to describe what Smyth had done he was then asked "you never got to like it", to which he replied, "no". Brendan Boland said:

> "So now they had established that I masturbated, alone. Again, I felt it put blame back on me; the blame and the shame. Because if I was masturbating, well, that was because I enjoyed it. And if I enjoyed that, well then I must have enjoyed being assaulted by Fr Smyth. Follow the logic."[60] [61]

Cardinal Brady agreed that some of the questions now made him cringe in horror.[62]

(3) At the end of the process Brendan Boland was asked to swear that he had told the truth, and "that I will talk to no one about this interview except authorised priests." We consider that an oath of secrecy should not have been imposed on this fourteen-year-old boy without the consent of his father.

59 Day 133, 25 June 2015, p.24.
60 *Sworn to Silence*, Brendan Boland, p.83.
61 FBS 70156.
62 Day 133, 25 June 2015, p.28.

64 In his witness statement[63] at paragraph 8 Cardinal Brady explained that:

> "In accordance with canonical procedure, and to protect the integrity of the evidence, an oath of confidentiality was administered to the witness, Brendan Boland, at the end of the hearing of evidence. This oath also protected the person giving the evidence as it allowed them to refuse to speak to the person they complained about and stop them from coming under pressure to change or withdraw their evidence. It also gave solemnity to the proceedings and formalised the evidence. This was important to ensure the evidence was clear and strong".

This may well be so, but it also ensured that this child was effectively silenced at the time, rendering him unable to discuss the events with his parents. As a result he could not receive, and his parents were prevented from giving him, the support that he could have received from them to enable him to try to cope with the abuse he had suffered and the response he received to his disclosure of it.

65 During the questioning, two further significant matters came to light. The first was that three other children, one boy and two girls, had gone on the same trip with Fr Smyth to Cork as Brendan Boland, and he was able to give the Belfast address of the boy, and to say in general terms where the girls came from in Co. Cavan. The second matter was that on another occasion Fr Smyth had taken Brendan Boland and another boy from Co. Cavan on a trip to Dublin where that boy was also abused by Fr Smyth.

66 Fr Brady reported back to Bishop McKiernan that he believed Brendan Boland's account. The bishop decided that to add weight to the evidence, and to corroborate Brendan Boland's account, the other boy from Co. Cavan should also be interviewed. He was interviewed on 4 April 1975, and this second interview took a broadly similar course to the first involving Brendan Boland, although there were some differences. On this occasion there were only two priests present, Fr Brady who asked the questions and the boy's curate Fr Duffy. FBS 39 was fifteen and seven months old at the time, and he was brought to where the interview took place in Co. Cavan by Fr Duffy. His parents were not told either before or afterwards of this interview and consequently were never asked for their consent to his being questioned in this fashion. Whilst several of the more objectionable questions asked in the first interview were not asked by Fr Brady on this occasion, at the end the child was asked to swear that his evidence

63 FBS 808.

was true, and that "I will not discuss this interview with anyone except priests who have permission to discuss it." Again Fr Brady recorded both the questions and the answers and afterwards reported back to Bishop McKiernan that he accepted the evidence of this boy as well, and as far as Fr Brady was concerned it was then for the bishop to take the matter forward thereafter.

67 As in the case of the first interview with Brendan Boland there are aspects of the interview of FBS 39 that merit criticism.

(1) The boy's parents were never told what was taking place, nor does it seem that they were ever informed by any clerical authority that their son had been abused by Fr Smyth.

(2) The boy was only accompanied by another priest during interview.

(3) He was also required to sign an oath saying he would not discuss the matter with anyone except priests who had permission to discuss it, and therefore was effectively silenced from telling anyone, and in particular his parents, what had happened to him. As in the case of Brendan Boland, this meant he could not receive, and his parents were prevented from giving him, the support that he could have received from them to enable him to try to cope with the abuse he had suffered and the interview he underwent in relation to it.

68 When asked to explain why oaths of secrecy of this sort were imposed on both children Cardinal Brady explained that this was to ensure that the witness would not be suborned, thereby weakening the effectiveness of the process. Whilst we accept that may have been part of the reason, we are in no doubt that the predominant reason for these oaths was to ensure that the good name of the Catholic Church would be protected by keeping the matters discussed secret. In his evidence to the Inquiry Cardinal Brady recognised that these interviews should never have been conducted in this way. He said:

> "There was a shroud of secrecy and confidentiality with a view to... about not destroying the good name of the church. The scandal that somebody who was ordained to serve people should so abuse the trust as for their own pleasure was appalling and it was...and to offset that scandal it was kept very secret, very, very secret, and everybody involved in it...I mean... were bound to secrecy."[64]

64 Day 133, 25 June 2015, pp.33 and 34.

69 Although we are critical of the manner in which they were conducted we do not consider that the conduct of the two interviews could be said to be relevant to the abuse committed by Fr Smyth, and therefore we do not consider it appropriate to make findings of systemic failings in relation to the conduct of the two interviews. **However, as we explain later, we consider that the use to which this information was put amounts to systemic failings on the part of those concerned.**

The Reaction of the Bishop of Kilmore

70 By 12 April 1975 Bishop McKiernan had received the results of both interviews, and on that day he went to Kilnacrott and discussed the situation with Abbot Smith.[65] The bishop suggested that the St John of God Brothers should be consulted and they suggested that Fr Smyth should go to Our Lady of Victory in Stroud run by the Paraclete Fathers to which we have already referred. Although Fr Smyth agreed to go to Stroud, he did not go until 13 November 1975.

71 As a priest in the Norbertine Order residing in Kilnacrott, Fr Smyth was outside the jurisdiction of the bishop of the diocese within which the Abbey was physically located. However, in order to exercise his priestly functions outside the confines of the Abbey, for example when hearing confessions or acting as a substitute for a priest in the diocese, Fr Smyth required the bishop's permission, a process known as the faculty to hear confession when that was the sacrament he was exercising. It appears to be the case from a memorandum compiled of an interview with Bishop McKiernan in 1994[66] that he believed the only course open to him was to withdraw the power to hear confessions from Fr Smyth, although in some circumstances – which he considered did not arise in this case – he could withdraw Fr Smyth's power to celebrate the Eucharist. The bishop also observed that if he felt the abbot was not acting responsibly towards a priest such as Fr Smyth, then he as bishop could refer the matter to the Abbot General of the Order, but again that was something that he considered did not arise in these circumstances.

65 FBS 998.
66 FBS 40626.

72 We are satisfied that Bishop McKiernan was wrong to believe that his responsibilities were limited in this way. In the written submission on behalf of the Diocese of Kilmore and Cardinal Brady to the Inquiry after the public hearings in module 6[67] it was accepted that:

> "it is clear that the necessary and appropriate steps were not taken to stop Brendan Smyth from reoffending and the removing of faculties was a wholly ineffectual way to do this."

73 In his statement on behalf of the Diocese of Kilmore, Fr Kilduff stated at paragraph 19:[68]

> "The diocese would accept that the failure of Bishop McKiernan to report the matter to the civil authorities or to ensure that the matter was reported by Abbot Smith to the civil authorities was a failing on his part. In the light of what is now known about Brendan Smyth and about the compulsive nature of paedophilia, it is clear that the diocese should also have informed the civil authorities in the jurisdictions where those children lived. These children were named in the reports as having also taken part in excursions with Brendan Smyth."

74 By the end of the two interviews Bishop McKiernan was aware that children from his diocese, and from the Diocese of Down and Connor, had been, or very likely had been, sexually abused by Fr Smyth, and that this was the second such serious allegation against Fr Smyth to come to the bishop's attention in two years. The bishop appears to have taken no steps to consult the parents of either boy who was interviewed, nor did he take any steps to contact the parents of the girl from his diocese identified in the interviews to see whether she might have been abused. Nor did the bishop report the matter to An Garda Síochána or to social services in the Republic of Ireland, nor did he report the matter to the police and social services in Northern Ireland in respect of the allegations made relating to the named children who lived in Northern Ireland. There is no evidence that he contacted Bishop Philbin, the Bishop of Down and Connor, in whose diocese one of the boys who was alleged to have been abused lived, and where the other girl on that holiday also lived. Had Bishop McKiernan informed the authorities in the Republic of Ireland and in Northern Ireland then it is possible that steps might have been taken that would have led

67 FBS 50014.
68 FBS 748.

to the conviction and imprisonment of Fr Smyth at that time, thereby preventing other children who we now know were subsequently abused by him from being abused. Had Bishop McKiernan notified Bishop Philbin then appropriate steps could have been taken by him if he was so inclined. Although, given that no such steps were apparently taken by Bishop Philbin in later years when similar allegations were brought to his attention, we consider it probable that if he had been informed about this matter at the time he too would have failed to alert the authorities in Northern Ireland.

75 A further example of the unwillingness of bishops and others to take decisive action can be seen from the approach taken by Bishop Daly when Bishop of Down and Connor. Bishop Daly wrote to Abbot Smith on 11 February 1991 saying he had received more complaints that Fr Smyth was using visits to Belfast to "continue the practices about which we spoke some years ago". He went on to say:

> "It is not for me to say what action should be taken; but I hope that you will forgive me for saying that experience seems to show that therapy is not being effective and that more drastic steps seem imperative if further harm is not to be done and if the risk of very grave scandal – and indeed, almost certainly, of court proceedings – is to be averted."

Abbot Smith responded on 21 February with a placatory letter stating that Fr Smyth has assured him that there has been no incident of that nature for a couple of years now. It seems that Bishop Daly accepted this, because we have seen nothing to indicate that he pursued the matter any further at that time, despite his saying that he had received more complaints about Fr Smyth's conduct. We consider that Bishop Daly should have pursued this with Abbot Smith in a much more determined fashion.

76 We are also satisfied that it was open to Bishop McKiernan to institute ecclesiastical proceedings in order to have Fr Smyth laicised, that is, removed from the priesthood. The submission on 6 July 2015 from the Archdiocese of Armagh[69] accepted that both Abbot Smith and the bishop could have instituted such proceedings.

77 We are satisfied that the steps taken by Bishop McKiernan in response to the information he received were wholly inadequate. In its submission, the Diocese of Kilmore accepted that Bishop McKiernan's failure to report the matter to the civil authorities was a failing, and the diocese also accepted

69 FBS 50027.

that the civil authorities in both the Republic of Ireland and Northern Ireland should have been informed.[70] **We agree, and are satisfied that the failures of Bishop McKiernan to:**

(1) inform the parents of the children from both his diocese and the Archdiocese of Armagh (i.e. Dundalk) named in the two interviews of what had or may have happened to their children;

(2) inform the Diocese of Down and Connor of what had, or may have, happened to the two children from Belfast;

(3) inform the police and social services in both the Republic of Ireland and Northern Ireland of the names of the children whom Fr Smyth was believed to have abused;

(4) invoke the appropriate canonical (that is ecclesiastical) procedures against Fr Smyth to have him laicised, together with his suggestion that Fr Smyth should seek further medical treatment when the bishop had reason to believe from what Abbot Smith had told him that earlier treatment of Fr Smyth had been unsuccessful, all amount to systemic failings on his part.

The Response of Abbot Smith, the Kilnacrott Norbertine Community and the Norbertine Order

78 There are few details available about Fr Smyth's stay in Stroud in 1975 because at the time it was policy to destroy records after five years. It appears that when Fr Smyth went to Stroud in November 1975 he stayed there for four weeks, but was told that there was no treatment programme available for his problem. He therefore appears to have treated the four weeks he spent there as a retreat.[71] Apart from the four weeks he spent in Stroud in November and December 1975 Fr Smyth appears to have been based in Kilnacrott Abbey until 1980 or 1981 when he was assigned to the Diocese of Fargo in North Dakota in the USA. He went there to serve as a parish priest and remained there in that capacity until April 1983. During the five years or thereabouts between the events of March – April 1975, which we have considered, and his going to Fargo, extracts from minutes of meetings at Kilnacrott produced to the Inquiry show that Fr Smyth's situation was discussed by Abbot Smith and his council on ten occasions.

70 FBS 50015.
71 FBS 828, paragraph 46.

It is noteworthy that there is no reference on any of these occasions to any consideration of the interests of those children who Fr Smyth had already abused, or whom he might abuse in the future, nor to the possibility of reporting him to the police or social services. It is significant that in May 1976 Abbot Smith is recorded as saying that Fr Smyth's case had been going on for "a number of years". In May and June 1978 there were discussions about limiting his use of a car. In May 1978 there was a suggestion made that Fr Smyth might consider laicisation, and in June 1978 it was agreed that the Abbot General and the Prosecutor General of the Order be informed about Fr Smyth. Whatever the Abbot General and other high ranking office holders in the Norbertine Order may or may not have known about Fr Smyth prior to then, it appears that he had now been officially reported to the highest authorities in the Order. In any event, the Constitutions of the Order provided for the regular visitations of each abbey or canonry to be carried out by visitators. We are satisfied that in all probability the highest levels of the Norbertine Order knew of Fr Smyth's behaviour by the late 1970s and probably did so some years before then. Because of this report, or because the visitators inspected the council minutes in Kilnacrott, they must have been aware of the entries in those minutes relating to him. We are satisfied that the highest authorities in the Norbertine Order were aware of Fr Smyth's conduct by this time.

79 **We consider that the failure of the Abbot General to take any action to prevent Fr Smyth continuing to abuse children, for example by instituting proceedings to have him laicised, represents a systemic failing by the Order.** That failure stands in stark contrast to the expulsion described to us by Fr William Fitzgerald[72] of an abbot by the General Chapter.

80 None of the steps to inhibit his movements that were discussed at any of these meetings appear to have been taken, because, as we shall see, Fr Smyth was able to continue to travel wherever he wished to go, and to do so completely unsupervised. Because of this lack of action Fr Smyth was free to abuse children for almost a further twenty years. By October 1979 the Abbot's Council discussed sending him to the Diocese of Fargo in North Dakota in response to the urgent need for priests in that diocese. Despite all that was known of Fr Smyth's abuse of many children, and the advice of Prof Moore in 1973 that wherever Fr Smyth was stationed his superior should be alerted to his proclivities, it was decided by the Abbot,

72 Day 132, 24 June 2015 at pp.79 and 80.

advised by his council at Kilnacrott, that the Bishop of Fargo should not be told of Fr Smyth's past. Abbot Smith is recorded as saying that he would like Fr Smyth's "going out from the House to have nothing against him", no doubt fortified in this approach by the recollection of one of the council that the Abbot General had sent a message "that Kilnacrott was not so obligated".[73]

81 **We are satisfied that the failure of the Order, Abbot Smith and his colleagues at Kilnacrott to take any effective steps to restrain Smyth from contact with children, to report him to the police and social services in the Republic of Ireland, and to ensure that he was laicised, constitute systemic failings on their part.** Fr Michael Toner, the chancellor of the Archdiocese of Armagh, referred to the "pusillanimity of those responsible in the Church for disciplining" Fr Smyth in the early 1970s.[74] But we consider that the conduct of the Norbertine Order in respect of Fr Smyth by the late 1970s was more than mere pusillanimity. The Order completely ignored the safety of the children with whom they must have known that Fr Smyth was in frequent contact when he was outside the abbey. For example, when Fr William Fitzgerald served as Rector of the Abbey Church at Kilnacrott for two years from 1987 he described how it was notorious at that time that the boot of Fr Smyth's car was filled with sweets.[75] Not only that, but the Order actively placed him in positions of trust, as when he was sent for a period as a hospital chaplain in Cork. The persistent refusal of the Order to take any effective steps whatever to control Fr Smyth was compounded by the decision to send him back into parish ministry in the USA. At all times their behaviour demonstrated they were only concerned with Fr Smyth's interests, and ignored the risk he posed to children. **Their failure to take any effective action in relation to Fr Smyth's known and repeated abuse of children represents a systemic failing on the part of the Order.**

82 We have examined Fr Smyth's activities and the responses of his colleagues in the Order in Kilnacrott Abbey and elsewhere by the mid to late 1970s in detail because they demonstrate many systemic failings on the part of those concerned. Despite the overwhelming evidence they had that Fr Smyth persistently sexually abused children, the Order allowed him to continue in his privileged position as a priest, a position which he betrayed

73 FBS 840.
74 FBS 50027.
75 Day 132, 24 June 2015, pp.46 and 47.

again and again in Northern Ireland and elsewhere for almost another two decades.

Fr Smyth's Activities in Residential Homes in Northern Ireland

83 It is against this background that we now turn to examine his behaviour in Nazareth House and Nazareth Lodge in Belfast, Rubane near Kircubbin in Co. Down, and St Joseph's Home for Girls in Middletown, Co. Armagh, four of the residential homes in Northern Ireland within our Terms of Reference.

St Joseph's Training School, Middletown, Co Armagh

84 NHB 8 was in St Joseph's Home in Middletown between May 1973, when she was fourteen, and April 1975, when she left the training school aged sixteen. Her younger sister HIA 195 was also there from September 1977, when she was fifteen, until she left in February 1979 aged sixteen. In 1994 NHB 8 told the police that she had been introduced to Fr Smyth when she was in Nazareth House. She alleged that he sexually abused her there and elsewhere before she was sent to Middletown. She alleges that when she was in Middletown she was visited by Fr Smyth who took her out in his car on trips, including one to a local hotel. She alleged that he had full sexual intercourse with her on at least six occasions. She also alleged that she told her house mother in St Joseph's that Fr Smyth was "doing" things to her, and she wanted someone to accompany her when she went out with him in future. She also alleged that Fr Smyth sent her a Valentine card in extremely coarse terms which she showed to SJM 11 of the Sisters of St Louis, who was director of the training school at Middletown.

85 SJM 11 told the police that diary records kept by the school recorded visits by Fr Smyth on 2 October 1973, 13 November 1973 and 21 March 1974. The entry for the last date read "Smyth called to see [NHB 8] today. He is really very good to her and comes so often to see her – never empty handed". SJM 11 told the police that NHB 8 would not have been allowed to leave the training school with Fr Smyth or anyone else. She did recall one occasion when she was told by a staff member that Fr Smyth had called to see NHB 8, but she did not wish to see him. SJM 11 relayed this to Fr Smyth who left, and, as far as she knew, that was the last time he came to Middletown. She denied that she had ever seen a Valentine card, or that NHB 8 had brought any allegation of sexual abuse to her attention.

86 There is no doubt that Fr Smyth did visit Middletown in 1973 and 1974 to see NHB 8, but in view of the conflict between the accounts given by NHB 8 and SJM 11 to the police in 1995, and in the absence of further evidence, we do not feel able to reach a conclusion as to whether or not NHB 8 was sexually abused by Fr Smyth whilst she was in the care of Sisters of St Louis at St Joseph's Training School in Middletown. Therefore we do not make any finding as to whether or not there were any systemic failings on the part of the Sisters of St Louis in relation to any sexual abuse to which NHB 8 may have been subjected by Fr Smyth whilst she was resident in St Joseph's Training School.

Fr Smyth and the Sisters of Nazareth

87 It is unclear when Fr Smyth first started to abuse children in Nazareth Lodge and Nazareth House, the homes run by the Sisters of Nazareth in Belfast which we consider elsewhere in this Report. In December 1994 Fr Smyth told police that he knew one of the sisters before she became a nun, and when she was sent to Nazareth Lodge he renewed their acquaintance by visiting her there occasionally. The sister concerned was FBS 53 who was in Nazareth Lodge between October 1973 and June 1974. He said that his visits to Nazareth Lodge were only to see her, and that it was not until sometime after he conducted a retreat for the Sisters in Nazareth Lodge that he became a regular visitor. There is a record of Fr Smyth conducting such a retreat for a week at the beginning of January 1976.[76] He described to the police how he lived in Nazareth House during the week of that retreat and that that was when he got to know people there.[77]

88 We are satisfied that from January 1976 Fr Smyth's familiarity to the nuns, and the respect in which he was clearly held by them as a result of the favourable impression he made on them by his conduct of the retreat in January 1976, enabled him to establish himself as a regular visitor to Nazareth Lodge, and to a lesser extent to Nazareth House. His position as a priest, his powerful personality, and the interest he showed in children meant that he was very well regarded by the sisters, and so was able to build up acquaintanceships he made with children whom he befriended in the homes, or whom he already knew or knew of through their families before they entered these homes.

76 FBS 10612.
77 FBS 30275.

89 As a result of a series of extensive and thorough investigations carried out by the RUC in the early 1990s following the publications in newspapers of allegations of sexual abuse by Fr Smyth, a large number of individuals were interviewed by the police. Many of these alleged that they were abused by him in their homes, at school, or on trips and excursions with him, all of which are matters outside the Terms of Reference of this Inquiry. Fifteen of those interviewed at that time were in either Nazareth Lodge or Nazareth House as children. Twelve of those who had been in Nazareth Lodge, and three of those who had been in Nazareth House, made allegations of sexual abuse by Fr Smyth. In due course he pleaded guilty to charges of indecent assault relating to eight children, boys and girls, in both homes. These were part of the larger total of 43 charges relating to offences against 21 children in Northern Ireland.

90 There can be no doubt that children in Nazareth Lodge and Nazareth House were abused by Fr Smyth. Given that the details of these offences have been ventilated in the criminal proceedings at Belfast Crown Court in 1994 and 1995, and during the hearings conducted by the Inquiry into Nazareth Lodge, Nazareth House and Rubane, it is unnecessary to set out the details of each offence in this report. We therefore concentrate on those features of Fr Smyth's activities that are relevant to our Terms of Reference. The first question to determine is when the abuse in Nazareth Lodge and Nazareth House by Fr Smyth started. A number of those who described being abused by him in Nazareth Lodge said that this happened before 1976, in some cases as early as 1973 or even earlier. Whilst we cannot exclude the possibility that Fr Smyth did abuse children in Nazareth Lodge before 1976, we consider that many of those who were abused by him, and who said to the police or to the Inquiry that he abused them in Nazareth Lodge before January 1976, may be genuinely mistaken about the time when the abuse occurred. We consider that as the nun who was acquainted with Fr Smyth was in Nazareth Lodge between October 1973 and June 1974, and as he admitted that he visited her, we consider it is more likely that the abuse commenced after he conducted the retreat in January 1976, because that appears to have been the start of his frequent visits to Nazareth Lodge. We consider it unlikely that he had the opportunity to show an interest in individual children on any visits he made solely to see the nun with whom he was acquainted. This has to be contrasted with the greater frequency of his visits, and the sisters therefore being more familiar with him, after he conducted the January

1976 retreat. In addition to his visits to see children, he occasionally said Mass for the sisters in Nazareth Lodge.[78]

91 It is clear from the evidence given by witnesses to the Inquiry, and from the many police statements gathered by the RUC during their investigations that led to his convictions in Northern Ireland in 1994 and 1995, that Fr Smyth would strike up an acquaintance with a young child. He would begin by showing an interest in the child, often taking the child in his car for treats. In particular he gave sweets and money to them as inducements to come to him when he called again. He had the ability to display an interest in young children which flattered them. This, together with his position as a priest, meant that he was able to entice them into his company. Two examples will suffice. HIA 41 said of Fr Smyth in his 1995 police statement:

> "he was extremely friendly towards me. I would have described him as a Santa Claus type man, he gave me sweets and money. I saw him on several occasions while I was in Nazareth Lodge. On each occasion he gave me sweets and money."[79]

In his 1995 statement DL 40 described how, when he was an altar boy, he was walking along a dark corridor in Nazareth Lodge with Fr Smyth when:

> "He stopped and started to kiss me right on the lips. He got down and pulled me towards him and he felt my backside on the outside of my trousers. He would have done this for approximately ten minutes. I was young with no mother and father and I thought he was just being kind to me. He did this on a number of occasions whenever he was in Nazareth Lodge saying mass. He was very crafty and this happened on a one to one basis."[80]

Fr Smyth attracted young, vulnerable children because of the interest he showed in them, and the sweets and money he lavishly distributed. He was clearly an alluring figure to many of the children in the home who were initially flattered by the interest of this apparently kindly and generous priest towards them, and then were dominated by him and by his priestly status when he abused them.

92 The next question is whether the Sisters in Nazareth Lodge and Nazareth House were at fault in not preventing Fr Smyth from having access to the

78 FBS 713.
79 FBS 30777.
80 FBS 30069.

children in their care. Central to any consideration of Fr Smyth's ability to abuse children, whether in their own homes, in schools, on holiday trips, or in children's homes such as Nazareth Lodge and Nazareth House, was his status as a priest. We are satisfied that unless an individual, or those responsible for children in any such situation, had reason to suspect that Fr Smyth was a serial child abuser, they would never have imagined that a priest could be capable of such behaviour. These events occurred long before the revelations in Northern Ireland, in the Republic of Ireland and elsewhere across the world, notably since Fr Smyth's own conviction in the 1990s, that, tragically, priests and clerics of all Christian denominations have taken advantage of their privileged position to engage in sexual and other forms of abuse of children.

93 The great respect in which Roman Catholic priests and other religious were held by their flocks in Ireland meant that for many clergy, brothers or nuns, and lay people, it was instinctive to place absolute trust and confidence in priests such as Fr Smyth. That trust, and the deference shown to clergy and religious that was in part a consequence of that trust, meant that fellow clergy, religious such as brothers and nuns, and parents of children, welcomed the interest Fr Smyth showed in children, and had no reason to suspect that his interest was a cloak for his perverted sexual desires. In this instance, unless the Sisters of Nazareth had reason to be concerned about Fr Smyth, it is not surprising that he was welcomed to Nazareth Lodge when he came to say Mass, or when he came to enquire after children whom he knew, or had got to know, in Nazareth Lodge or Nazareth House. In those circumstances, unless there was some reason to be concerned, we do not consider that the Sisters of Nazareth would otherwise be guilty of any systemic failing on their part by allowing Fr Smyth contact with the children in their care.

94 The next question is whether the Sisters of Nazareth in either of these homes had any reason to be concerned about Fr Smyth. Although the Norbertine Order may not have known exactly where he was going, nevertheless it was known to members of the Order that Fr Smyth visited Belfast from time to time. The Order did not inform anyone else, including the Diocese of Down and Connor where these homes were located, about Fr Smyth's behaviour. The Diocese of Kilmore did not alert any other diocese about Fr Smyth, nor, as we shall see, did the Diocese of Down and Connor alert any other diocese when it became aware of allegations regarding Fr Smyth. However, there have been allegations that individual

sisters in Nazareth Lodge had reason to be concerned about Fr Smyth's behaviour towards the children in their care. HIA 50, alleged that SR 2 unexpectedly came into a room and surprised Fr Smyth in the act of anal intercourse with him. This was denied by her when she was questioned by the police. We are not persuaded that such an episode occurred, or that SR 2 would have failed to take immediate action in relation to Fr Smyth had she witnessed one of the children in her care being abused in this fashion.

95 HIA 195, one of the children whom Fr Smyth admitted abusing, told the police that she told SR 31 what Fr Smyth had done after the first occasion he abused her, but was not believed and was hit on the head with a bunch of keys. SR 31 denied to the police that she had been told, but we see no reason not to accept HIA 195's account. **We consider that SR 31's failure to report the matter to the mother superior was a systemic failing on the part of the Sisters of Nazareth.**

96 In any event, SR 46 admitted to police in 1995 that NL 88 did tell her that she did not like Fr Smyth, and that he had rubbed against her breasts. SR 46 said her response to NL 88 was "I said well in future when you see him stay out of his way".[81] She went on to say that she did not doubt NL 88, that Fr Smyth "gave her the creeps", and she wondered why he was writing to NL 88's siblings. Because she was not happy with Fr Smyth being around she said that she kept "extra observation",[82] but did not tell her colleagues what she had been told. We accept that whilst she may have been naive, nevertheless in the light of her own suspicions and what she had been told and did not doubt, we consider that she should have reported this episode to the mother superior. Had she done so then the matter should have been investigated. At the very least, it could have led to Fr Smyth being barred from the premises and further acts of abuse thereby being prevented. **We consider that the failures of SR 31 and SR 46 to report the complaints made to them about Fr Smyth to the mother superior were systemic failings on the part of the Sisters of Nazareth.**

81 FBS 32708/9.
82 FBS 32710.

Fr Smyth's Visits to the Boys Home at Rubane, Kircubbin, Co Down

97 As explained elsewhere in our Report, for many years when boys from Nazareth Lodge reached the age of eleven they moved to the home run by the De La Salle Brothers at Rubane near Kircubbin, Co. Down. As we have seen in respect of NHB 8 at Middletown, Fr Smyth often kept in touch with children he had abused after they moved elsewhere, something he also did with children he had abused in their own homes or elsewhere. In the 1990s DL 59 said to police that he knew Fr Smyth in Nazareth Lodge. Fr Smyth did not abuse him there, but did abuse him when he came to visit DL 59 in Rubane. Masturbation and kissing occurred on a number of occasions, after which Fr Smyth gave him sweets or money. He says he told BR 1 but said nothing more because BR1 also abused him.[83] Another child who was abused by Fr Smyth in Nazareth Lodge, and who was visited by Fr Smyth when he was in Rubane, was HIA 41. In 1995 he described how Fr Smyth visited him in Rubane on a few occasions. During these visits Fr Smyth touched him on his bottom and on his penis inside his trousers. Fr Smyth gave him sweets.[84] The accounts of both describe how they were told that Fr Smyth wanted to see them, and they were then taken to a room in Rubane where they were left alone with him. We are satisfied that Fr Smyth probably visited other boys at Rubane who had been in Nazareth Lodge. Br Francis Manning's statement to the Inquiry of 5 June 2015 records a number of enquiries by Fr Smyth about children in the home, and Br Manning accepted that Fr Smyth visited Rubane on occasions after September 1977.[85] We are satisfied that Fr Smyth did abuse former Nazareth Lodge children in Rubane in the late 1970s before he left Ireland in the middle of 1980 to go to a parish in the Diocese of Fargo in North Dakota, USA, where he served until April 1983.

98 HIA 41 did not allege that he told the brothers at Rubane what Fr Smyth was doing to him, but DL 59 said he told BR 1 who also abused him. DL 40 says he told BR 1 that he had been abused by Fr Smyth, and that letters and visits from Fr Smyth then stopped. We accept that BR 1 was told what Fr Smyth was doing on these visits. Whilst BR 1 may have told Fr Smyth not to visit DL 40 again, nevertheless BR 1 should have reported what he had been told to the police and social services and to

83 FBS 30776.
84 FBS 30778.
85 FBS 645.

the Norbertine Order. As we explain in that part of our Report dealing with Rubane, we are satisfied that BR 1 himself abused children in Rubane. We are satisfied that whilst BR 1 may have prevented Fr Smyth from returning to Rubane to see DL 40, BR 1 did nothing else to prevent further abuse by Fr Smyth of children in the care of the De La Salle Order. We are satisfied BR 1 failed to report the allegations about Fr Smyth to his superiors in the De La Salle Order, and to the police and social services. **We consider that these failures constitute systemic failings on the part of the De La Salle Order.**

The Diocese of Down and Connor and the Whitehead events of 1976

99 In its researches into the materials obtained by the Inquiry, material was found by the Inquiry indicating that in 1976 FBS 51, a priest of the Diocese of Down and Connor, became aware that Fr Smyth had sexually abused children in the parish in Whitehead where FBS 51 served as a curate at the time. The priest was approached by FBS 40 who told him his sister had been sexually abused by Fr Smyth. Whilst the exact sequence of events thereafter is somewhat confused, it is clear that FBS 51 took FBS 40 with him to a meeting with the Prior of Kilnacrott. FBS 51 said the meeting was in the Ballymascanlon Hotel near Dundalk, whereas FBS 40 said the meeting was at a hotel outside Dublin. Be that as it may, we believe that this meeting in 1976 is probably the meeting referred to by Fr William Fitzgerald at paragraph 43[86] of his statement to the Inquiry, a meeting which he understood happened in or around 1974. As Abbot Smith was abroad at the time, it was the Prior of Kilnacrott who met the family. FBS 40 told the prior what had happened to his sister, as well as his suspicions about another member of his family, and members of another family, who he thought might also have been abused by Fr Smyth.

100 Although there is no contemporary record in Kilnacrott of this meeting in 1976, in his statement to the Inquiry FBS 51 confirmed that such a meeting took place. In 1995 he told the police:

> "I felt that bringing Abbot Smith's attention to Fr Brendan Smyth's alleged behaviour was the appropriate course of action open to me. It never entered my mind to go to the police in those days it was always

86 FBS 827.

open to the children's parents to go to the police if they felt it was necessary." [87]

FBS 51 did not report this meeting to his bishop at the time. Some years later he heard that Fr Smyth was trying to get work in the Diocese of Down and Connor so he wrote to Bishop Philbin who was the bishop at the time. FBS 51 cannot recall when he wrote to the bishop, but it must have been before 1981 when Bishop Philbin retired. In 1995 FBS 51 said that the bishop acknowledged the letter, and said that he, the bishop, had also heard rumours about Fr Smyth. Given that Fr Smyth went to North Dakota in June 1980[88] this exchange of letters may well have been in 1978 or 1979 because that was the time when the Kilnacrott council minutes record that the Norbertine Order at Kilnacrott were discussing the possibility of priestly work for Fr Smyth.[89]

101 We accept that Bishop Philbin was notified of these allegations, probably in the late 1970s. We consider that he should have reported the matter to the police and to social services at that time, and **we consider his failure to do so, and the failure of FBS 51 to do so, were systemic failings on the part of the Diocese of Down and Connor.**

102 As the abuse perpetrated by Fr Smyth in the residential homes in Northern Ireland within our Terms of Reference appears to have been committed in the 1970s before Fr Smyth went to the Diocese of Fargo between 1980 and 1983, we can therefore deal with the events of the 1980s that are relevant to our Terms of Reference relatively briefly. It is a telling indication of the effect of Fr Smyth's personality on so many people that a petition was signed by many of the parishioners of his parish in the Diocese of Fargo protesting at his removal less than three years after his arrival. On his return to Ireland Fr Smyth continued to live in Kilnacrott, where it appears he performed his ministry without any apparent concern on the part of his colleagues in Kilnacrott for the safety of the children with whom he might come in contact. Upon Fr William Fitzgerald's arrival at Kilnacrott as rector of the Abbey Church in 1987 he found Fr Smyth in charge of the altar servers and the children's choir.[90] It is to Fr Fitzgerald's credit that he stopped Fr Smyth having any further contact with either group of children.

87 FBS 32151.
88 FBS 899.
89 FBS 839.
90 FBS 823.

103 Fr Fitzgerald explained to the Inquiry[91] that during the period from Fr Smyth's return from North Dakota in 1983 and March 1989 Fr Smyth held no formal ministry or office in the abbey. However, in 1984 the abbey requested Bishop McKiernan to restore Fr Smyth's faculties and this was done. Instead of the normal practice of granting faculties indefinitely they were renewed from time to time. According to the statement of Fr Donal Kilduff of Kilmore Diocese to the Inquiry, Bishop McKiernan consulted Abbot Smith and "was satisfied that there did not appear to have been any further occurrences similar to those previously complained of."[92] If that is correct, we can only assume that Abbot Smith deliberately concealed from Bishop McKiernan that Fr Smyth had been returned from the Diocese of Fargo in disgrace when Bishop McKiernan was requested to renew Fr Smyth's faculties. Fr Kilduff suggested that:

> "The limited nature of the return of the faculties suggested that Bishop McKiernan wanted to monitor Brendan Smyth to ensure he did not come up in any further complaints but that he believed that the treatment discussed had taken place and that it worked."[93]

104 The Norbertine Order continued to request, and were granted, renewals of Fr Smyth's faculties by Bishop McKiernan until October 1993. This was done despite Abbot Smith telling his council that Fr Smyth "had been involved in certain improper and wrong behaviour in regard to a boy in Northern Ireland", and that as a result Fr Smyth then saw Dr Del Monte, a clinical psychologist in Dublin, for several years thereafter. In addition in March 1990, Bishop (later Cardinal) Cahal Daly of Down and Connor had gone to Kilnacrott and discussed Fr Smyth's actions with Abbot Smith. Bishop Daly told the abbot that Fr Smyth had been reported to the police, and that three of his priests had told Bishop Daly that Fr Smyth had been involved "in apparent unlawful behaviour with young persons".[94]

105 We can only conclude that at that time Abbot Smith did not tell Bishop McKiernan of these vital matters because Abbot Smith continued the longstanding policy of doing everything possible to conceal Fr Smyth's activities from any ecclesiastical or civil authority to enable Fr Smyth to continue to exercise his priestly duties wherever possible, despite the overwhelming evidence that Fr Smyth was, and continued to be, a

91 FBS 829.
92 FBS 747.
93 FBS 747.
94 FBS 829.

danger to children. **We are satisfied that Abbot Smith's failure to tell Bishop McKiernan that Fr Smyth was the subject of continuing complaints of child sexual abuse represents a further systemic failing on the part of the Norbertine Order.** This failure resulted in Fr Smyth's faculties being continued and gave him the opportunity to abuse more children. Fr Smyth took advantage of this opportunity and continued to abuse children in the Republic of Ireland until 1993, offences for which he was later sentenced at Dublin Circuit Court on 22 April 1997.[95]

The Diocese of Down and Connor

106 We have already referred to Bishop Philbin being told about the Whitehead allegations, and to the meeting between Bishop Daly and Abbot Smith in 1990. It is noteworthy that just as Bishop McKiernan of Kilmore failed to inform the Diocese of Down and Connor of allegations relating to children living in that diocese, so both Bishop Philbin and Bishop Daly failed to inform Bishop McKiernan of Kilmore Diocese that a priest living in an abbey located in his diocese had been the subject of allegations of sexual abuse. Had the respective bishops so informed their fellow bishops then there would have been at least some prospect that all concerned would have been spurred into action to take more vigorous steps to ensure that Fr Smyth was unable to travel across the island of Ireland, both North and South, and elsewhere, and so unable to abuse a large number of children. **We regard their failures to take any steps to disseminate this information to their fellow bishops as systemic failings on the part of the Dioceses of Kilmore and of Down and Connor.**

Conclusions

107 During their evidence to the Inquiry the Diocese of Kilmore, the Diocese of Down and Connor, and the Norbertine Order, have expressed their sorrow and regret to the victims of many of the systemic failings they have accepted and those which we have identified. Perhaps the most eloquent of these apologies are the words of Fr Timothy Bartlett in his statement to the Inquiry of 5 June 2015 on behalf of the Diocese of Down and Connor:

> "No apology can ever make up for the appalling abuse that the victims of Brendan Smyth, and their families, have endured through the repeated failure to deal effectively with his criminal behaviour over a long period of

95 FBS 32670.

time. On behalf of the Diocese, therefore, I conclude by expressing deep sorrow and the most profound regret that so many people, many of them in positions of trust and responsibility in the Church, failed so many times to respond to the cries of the 'little ones', those whom our fundamental, human and Christian instincts alone should have compelled us to protect and reach out to as a first priority."

The Nature of Fr Smyth's Abuse of Children

108 In the evidence available to us differing accounts have been given of the nature and extent of the manner in which Fr Smyth sexually abused children. Other than in those few instances where we have already commented upon specific allegations we do not consider it necessary to explore what may appear to be inconsistencies in some of these accounts. This is because we are entirely satisfied that, as he admitted, Fr Smyth sexually abused a great many children, some of whom were abused by him when they were resident in those residential homes in Northern Ireland which fall within our Terms of Reference.

The Effect of Fr Smyth's Abuse on his Victims

109 Fr Smyth abused a great many children in different ways. Irrespective of what he may have done to each individual child, the effect on each of them will undoubtedly have been significant in later years. Perhaps the remarks of Fr William Fitzgerald to the Inquiry[96] apply to all those whose lives Fr Smyth blighted by his actions, and who have to live with the effects of their experiences at his hands for many years, if not for the rest of their lives.

> "...the youngest victim of Brendan Smyth that I know of is 28-years-of-age. She is going to be around for another 60 years maybe or longer, and every day of her life the horrible spectre of that man will be in her mind and what he did. How can -- how can anyone return anything to – I mean, like give her €100 million. It would do nothing to repair any damage that has been done to her. It's unspeakable, unspeakable."

110 The evidence which we have reviewed leaves us in no doubt that over many years the Norbertine Order, and others within the Roman Catholic Church, failed to take determined and vigorous steps to ensure that Fr Smyth would never abuse more children. We regard it as particularly significant

96 Day 132, 24 June 2015 at p.72.

that the existing Canon Law procedures that could have been invoked to bring his crimes to an end were resorted to on only one occasion, namely during the Kilmore investigation of March and April 1975. Even in that instance steps to have Fr Smyth laicised were not taken. For the Norbertine Order, and for others outside the Order in positions of responsibility in the Church, their overriding priority throughout was to protect the good name of the Church, and at all times to prioritise Fr Smyth's interests, instead of doing what was best for the children abused by him. By doing so they were prepared to ignore their responsibilities under the Canon Law of the Church, and their obligations under the criminal law, as well as their moral responsibilities to the victims of his abuse, thereby allowing him to continue to abuse children far and wide for many decades.

Findings of Systemic Failings

111 In this Chapter we have stated on each occasion when we consider there were systemic failings. Rather than repeat each finding we have summarised those findings below. As these are summaries, it should be appreciated that some headings may encompass several distinct findings of systemic failings of the same type. The Summary is not meant to replace those findings, and the individual findings represent our definitive findings.

The Norbertine Order

(1) Permitting Fr Smyth's ordination despite a clear warning from the Abbot General that Fr Smyth should not be ordained.

(2) Failing to:

(a) properly assess the grave risk Fr Smyth posed to children; and and/or

(b) warn the bishops of the dioceses to which he was sent in later years, namely

- **Menevia in Wales**
- **Annan in the Diocese of Galloway**
- **Providence, Rhode Island, USA**
- **Fargo, North Dakota, USA.**

(3) Taking deliberate decisions to withhold information about Fr Smyth's background when he was sent to other dioceses.

(4) Giving advice from the Abbot General that it was not necessary to send that information to other dioceses.

(5) Failing to act on credible reports of Fr Smyth's sexual abuse of children.

(6) Allowing repeated efforts to be made to 'cure' Fr Smyth by sending him for various forms of medical treatment on several occasions, even though it was clear from continuing complaints that, despite earlier treatments, he was continuing to abuse children.

(7) Failing to insist that he provided adequate information as to the nature and extent of his treatment, and the prognosis, from the various doctors who treated him.

(8) Deciding not to withdraw his access to a car, thereby enabling Fr Smyth to travel freely and abuse children in many homes and locations in both Northern Ireland and the Republic, even after he had been charged by the police in 1991.

(9) Failing to confine Fr Smyth to the Abbey in Kilnacrott and thereby keep him away from children.

(10) Failing to report Fr Smyth to the police and social services in either Northern Ireland or the Republic of Ireland, thereby preventing him from being prosecuted and convicted, and so enabling him to continue his abuse.

(11) Failing to have in place adequate procedures

  (a) to prevent Fr Smyth being ordained;

  (b) to have Fr Smyth reported to higher authority in the Order, and to the Congregation of Religious and for Secular Institutes in Rome when the members of the Order received definite information that he was committing crimes against children.

(12) Failing to notify the bishops of the Diocese of Down and Connor and the Diocese of Kilmore of the dangers Fr Smyth posed to children in their dioceses when he was known, or suspected, to be going to these dioceses.

(13) Failing to vigorously pursue the existing procedures and to notify the Congregation of Religious and for Secular Institutes of Fr Smyth's crimes.

Diocese of Kilmore

(1) **Failing to notify the police and social services in the Republic of Ireland when the 1973 complaint was received, and failing to institute ecclesiastical proceedings against Fr Smyth at that time.**

(2) **Failing to have Brendan Boland's father in the room with the child whilst the child was being questioned; and in the case of FBS 39 failing to notify his parents of the alleged abuse, or to have his parents present during questioning. In both cases there was also a failure to follow up with the parents of each child how the child was reacting to the abuse afterwards.**

(3) **Failing to take all the steps open to the diocese to thoroughly investigate each allegation relating to Fr Smyth that came to its notice and to report the matter to the proper civil and ecclesiastical authorities on each occasion.**

(4) **Failing to inform the civil and ecclesiastical authorities in Belfast about what had, or may have happened, to the two named children from Belfast.**

(5) **Failing to report the allegations relating to Fr Smyth to the Congregation of Religious and for Secular Institutes.**

(6) **Failing to exercise sufficient pressure on Abbot Smith to take vigorous action against Fr Smyth, such as laicisation or restricting his freedom of movement.**

(7) **Failing to use the existing process properly by short-circuiting matters and proceeding directly to investigate Fr Smyth instead of referring the matter to the Archdiocese of Armagh.**

(8) **Failing to ensure that all Fr Smyth's ecclesiastical faculties were permanently withdrawn.**

(9) **When the faculties were renewed from year to year, failing to take proper steps to ensure that Fr Smyth was not still offending.**

(10) **Failing to warn other dioceses, and in particular the Diocese of Down and Connor, about the allegations so that they could take steps to protect the children in homes in their diocese from being abused by Fr Smyth.**

The Diocese of Down and Connor

(1) The failures of SR 31 and SR 46 to report the complaints made to them about Fr Smyth to the mother superior.

(2) Failing to report the allegations against Fr Smyth to the social services and the police in Northern Ireland when they were received by the Diocese.

(3) Failing to institute a penal investigation or process against Fr Smyth in the Diocese of Down and Connor on the basis of the allegations of his abuse in that Diocese.

(4) Failing to exert greater pressure upon Abbot Smith in 1971, by (1) asking for urgent and immediate information, and for that to be confirmed; (2) threatening to institute the church inquiry process in Down and Connor against Fr Smyth as had been done in Kilmore by Bishop McKiernan.

The Sisters of Nazareth

(1) The failures of SR 31 and SR 46 to report what they had been told to the mother superior.

The De La Salle Order

(1) Failing to notify the police and social services in Northern Ireland of the allegations against Fr Smyth made to BR 1.

Chapter 11:

Module 3 – De La Salle Boys' Home, Rubane House

Introduction

1 The Inquiry devoted Module 3 to the examination of evidence relating to Rubane House (Rubane), a home run by The Institute of the Brothers of Christian Schools, a Roman Catholic male religious order, on behalf of the Roman Catholic Diocese of Down and Connor. The Institute of the Brothers of Christian Schools has always been best known throughout Ireland as the De La Salle Order and it will be referred to as the Order in this chapter of the report.

2 The Inquiry devoted 30 sitting days spread over eight sitting weeks to this module, commencing on 29 September 2014 and finishing on 17 December 2014. Fifty-seven former residents of Rubane applied to give evidence to the Statutory Inquiry and we heard oral evidence from 47 of them. The witness statements of six applicants were read to the Panel during Module 3: four were read because they were unable to attend for medical reasons;[1] and, sadly, two because the applicants died before they could give oral evidence[2].

3 The statements of two witnesses were also read because they had previously given evidence in person in Module 1, which dealt with the Sisters of Nazareth homes in Derry/Londonderry, and had only brief comments to make about their time in Rubane.[3]

4 We also heard evidence in Module 3 from two former residents of Rubane put forward as witnesses by the Order.[4] A statement from another witness[5] put forward by the Order was taken into account but we did not consider it necessary to ask him to give his evidence in person.

5 The statement of one witness[6] was discounted because he failed to attend to give evidence and provided no reason for his lack of attendance.

6 The evidence of four witnesses was heard in Module 4,[7] which dealt with the Sisters of Nazareth homes in Belfast, as these applicants had only brief comments to make about their time in Rubane. Three gave their evidence in person and the statement of the fourth was read because he was unable to attend for medical reasons.

1 HIA 16, HIA 160, HIA 262 and HIA 388.
2 HIA 159 and HIA 427.
3 HIA 381 and HIA 382.
4 DL 40 and DL 455.
5 DL 244.
6 HIA 260.
7 HIA 89, HIA 368, HIA 210 and NL 122/DL 208.

7 Therefore, in total, the Inquiry had the benefit of receiving evidence from 60 former residents of Rubane. Twelve of these former residents were admitted to Rubane in the 1950s, 26 in the 1960s, seventeen in the 1970s and five in the 1980s.

8 The Order provided written responses to each witness statement and we took these responses into account. We also received written statements from nine current and former brothers of the Order[8] who lived and worked in Rubane and received oral evidence from five of these brothers.[9] BR 2 gave evidence on two occasions; on the first he responded to allegations made against him and on the second, as a former brother director of Rubane, he provided more general information about how the home operated and was managed.

9 Brother Pius McCarthy, the Provincial Secretary to the Order in Ireland from 1974 to 1976 and from 1995 until his death in May 2014 provided witness statements and helpful background material to the Inquiry. The current Irish Provincial, Brother Francis Manning, also provided written statements and gave evidence in person on behalf of the Order.

10 Four former members of lay staff who worked at Rubane[10] gave evidence in person to the Inquiry. The Inquiry was only able to locate one former member of lay staff DL 11 towards the end of the module. We accepted there were good reasons why he could not attend in person at short notice and took his written statement into account.

11 The Inquiry also considered statements from the Department of Health, Social Services and Public Safety (DHSSPS) as the successor department to the Ministry of Home Affairs (MoHA) and the Department of Health and Social Services (DHSS), each of which had statutory responsibility for the registration and regulation of Rubane as a children's home. We heard oral evidence from Dr Hilary Harrison on behalf of the DHSSPS and from a former employee of the Social Work Advisory Group[11] who was involved in the regulation of Rubane.

12 The Health & Social Care Board (HSCB), as the successor to the various local or statutory authorities which had responsibilities for the care of children placed in Rubane, provided written evidence including statements

8 BR 2, BR 3, BR 7, BR 10, BR 25, BR 29, BR 33, BR 62 and BR 77.
9 BR 2, BR 7, BR 10, BR 29 and BR 77.
10 DL 1, DL 81, DL 509 and DL 149.
11 DL 521.

from fifteen current and former social workers who had experience of Rubane and from Valerie Watt, the current Chief Executive of the HSCB. We considered these statements and asked for, and received, oral evidence from five of these individuals.[12]

13 Father Timothy Bartlett, Episcopal Vicar for Education and Director of Public Affairs for the Diocese of Down and Connor, provided statements and gave evidence in person on behalf of the Diocese.

14 We also considered documentation relating to police investigations and civil claims against the Order that identified 158 former residents of Rubane who did not apply to the Inquiry but who alleged similar types of physical and sexual abuse as that alleged by witnesses to the Inquiry. Counsel to the Inquiry brought relevant information from these investigations and civil proceedings to the attention of the Panel during the public hearings. Rubane was considered by the Committee of Inquiry into Children's Homes and Hostels chaired by His Honour Judge William Hughes (The Hughes Inquiry) and we considered the findings of that Inquiry in relation to Rubane.

15 We also considered written and oral closing submissions from the De La Salle Order, the DHSSPS, the HSCB and eight individuals[13] against whom allegations of abuse were made. In total, we considered almost 40,000 pages of documentation in this module, 20,000 pages of which was provided by the police.

16 We are grateful to all the individuals and organisations that provided evidence and we appreciate the full co-operation we received from the Order, which provided detailed statements and copies of relevant documentation in a timely manner. We are particularly grateful to BR 2 for providing personal diaries that he kept from 1968 to 1976[14] while working in Rubane, which helped to confirm the dates of particular events and provided a contemporaneous record of his life in Rubane and some of the challenges he faced working there.

17 Fifty of the 60 former residents of Rubane who gave evidence said that they suffered physical abuse by brothers and lay staff and observed other boys being subject to such abuse. Fifty one said they were sexually abused by staff and/or their peers in Rubane and that they were aware of other

12 DL 503, DL 515, Mr Bunting, DL 516 and DL 517.
13 BR 2, BR 3, BR 10, BR 25, BR 62, BR 77, HIA 21 and HIA 147.
14 RUB 6000-7117.

boys being subject to such abuse. We also heard evidence from former residents about emotional abuse, neglect and unacceptable practices that they say they experienced in Rubane. We have given careful consideration to the written and oral submissions from former residents, however in accordance with our general approach and our Terms of Reference, we do not propose to refer to each and every detailed allegation that was made, whether against an individual or the institution.

18 The Order has pointed out what it considers to be factual inaccuracies and inconsistencies in aspects of the evidence provided by some witnesses. It has also pointed out that some witnesses have increased the number and/or seriousness of their allegations from the time they were first interviewed about them by the police to what they alleged in subsequent police interviews, evidence for civil claims and evidence provided to this Inquiry. Individuals accused of abuse have queried the detail of allegations and the reliability, credibility and motivation of witnesses and have pointed out that memory can be affected by the lapse of time and the emotional content of memories.

19 We understand it is difficult for some people to recognise and try to come to terms with the abuse they suffered as children and that many find it hard to speak about it to others, particularly where the abuse was of a sexual nature. A number of witnesses in this module told us that it was only when they decided to come forward to give evidence to this Inquiry that they spoke for the first time to their partners and families about their experiences in Rubane.

20 The Inquiry noted inconsistencies in evidence and contrasting recollections and perceptions of the same events. The dates given by some witnesses for their stays in Rubane differed from those in the register. While there may have been occasions when inaccurate entries were made in the register, we are inclined to believe that contemporaneous written records are generally more likely to be correct. We also noted that some witnesses, including former residents, brothers and lay staff, were not able to remember some events or the full details of some situations because of the time that had elapsed since they occurred.

21 However, it is important to emphasise that the purpose of our consideration is to determine whether, and if so to what extent, there were systemic failings in the care provided in Rubane; therefore, it is not necessary for us to make specific findings in respect of every allegation.

22 Before considering the evidence from former residents, we will first set out background information about the establishment and development of Rubane as a children's home, the statutory and regulatory frameworks within which it operated, the governance and management arrangements that pertained and the daily routine that boys experienced in the home.

The De La Salle Order

23 The Order was founded in France in 1680. The founder, John Baptist de La Salle established the community of teaching brothers to provide education for the children of the working classes in France. At first the Order was confined to France, but at the time of the French Revolution the brothers were dispersed and established Provinces throughout the world. The Order opened a novitiate in Ireland in 1880 and in 1891 it established a college in Waterford for the training of brothers and lay teachers. Prior to 1947 there was only one Province covering England, the Republic of Ireland and Northern Ireland. In 1947 the Irish Province became independent and responsible for schools and institutions in Ireland, north and south, including, in due course, Rubane House.

24 The head of the Order is known as the Superior General. The Superior General is based in Rome and is assisted by a group of councillors who together make up the General Council. Each Province has an appointed Provincial Superior (Provincial) who is delegated to run the Province in accordance with the Rules of the Order and each separate community or house has a Brother Superior or Brother Director. Since, in the main, Brother Director was the title used in Rubane for the brother who was the Head of the Community and the Officer in Charge of the Home, that is the title we will use in this report. During the thirty five years that Rubane operated as a children's home eight brothers were appointed as Brother Director and BR 2 held this role for three periods. Each Brother Director of Rubane was responsible to the brother who was Provincial of the Irish Province at the time of his tenure.

25 From October 1950 to September 1973 the Brother Director of Rubane was also the principal of the school in Rubane. On 1 September 1973, BR 4 was appointed principal of the school to enable BR 2 to concentrate on the management of the home and the leadership of the community of brothers. The pattern of appointing separate heads of education and care was adopted widely about this time throughout the United Kingdom in special residential schools and schools for young offenders. This

arrangement of a separate brother, and eventually a lay person, being in charge of the school continued until the closure of Rubane.

26 All the brothers who worked in Rubane were governed by rules and regulations set out in two books, namely:

- Rules and Constitutions of the Brothers of the Christian Schools
- Book of Government of the Brothers of the Christian Schools.[15]

27 These rules set out clear and detailed instructions about how brothers should behave towards each other, the boys in their care and the general public. They also set out directions to brothers about self monitoring and correction, disclosure of failings to the community and management of any lack of adherence by themselves or other brothers to the rules. A specific obligation was placed on brothers to report a breach of rules or misconduct by another brother to the Brother Director or, where the Brother Director was the source of concern, to the Provincial.

28 Detailed arrangements were specified for each brother to report and provide feedback to the Provincial about their conduct and life and progress within the community through the submission of individual private letters on an annual basis and through individual interviews during visits of the Provincial or his assistant.

29 The Order informed the Inquiry that the Provincial of the Irish Province, or on some occasions his assistant, visited Rubane at least once a year for a three-day period. It explained that in addition to reviewing the conduct of the brothers and their life as a community the Provincial or his assistant would review the needs of the home in respect of staff and funding, talk with religious and lay staff and interact with the boys.[16]

30 A 'History of the House' was maintained by the brothers in Rubane and between 1952 and 1970 a record of important events, as required by the Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland) 1952,[17] was also maintained. The Order has confirmed that both of these documents would have been available for inspection by the Provincial.

15 RUB 1786 to 1856.
16 RUB 021.
17 HIA 288.

The establishment of Rubane House

31 St Patrick's Training School (St Patrick's) in Belfast was one of the institutions operated by the Order in Northern Ireland and we consider it in Chapter 12 of this report. It was run by the Order on behalf of the Roman Catholic diocese of Down and Connor and the Brother Director of that school in 1950 was BR 39. A special meeting of the Governing Board of St Patrick's was held on 31 March 1950 chaired by the Most Reverend Dr Mageean, the then Bishop of the Diocese of Down and Connor. The meeting was convened to discuss the Children and Young Persons Act (Northern Ireland) 1950[18] which was due to come into force on 1 April 1950, and in particular the provision within it for Welfare Authorities to establish and maintain homes for children who were subjects of care orders on a separate basis from those children who were regarded as junior offenders. The Governing Board of St Patrick's decided at this meeting that specific provision ought to be made for children of the Roman Catholic faith who were subjects of care orders.[19]

32 This decision was influenced by the concerns of BR 39 that some children were being placed inappropriately in St. Patrick's because of the lack of suitable alternative residential accommodation for Catholic boys, and because Nazareth Lodge, a residential home for Catholic boys situated in Belfast and run by the Sisters of Nazareth, was overcrowded.[20] The Inquiry's consideration of Nazareth Lodge is set out in Chapter 9 of this report.

33 In April 1950, Bishop Mageean formally asked the Order to send five brothers to run a voluntary home and orphanage in his diocese. On 25 May 1950, the diocese purchased a large Victorian mansion, Rubane House, farm buildings, a coach house and 250 acres of surrounding land for £32,500. The property was situated near the shores of Strangford Lough, near Kircubbin, County Down, approximately 22 miles from Belfast. Although the Order repaid the cost of the purchase with interest, the legal ownership of the House and land remained at all times with the diocese.[21] The diocese and the Order entered into a formal agreement about the operation and management of Rubane House on 3 October 1950.[22]

18 HIA 164-286.
19 RUB 40008 and RUB 10014.
20 RUB 10001.
21 RUB 072, RUB 10010, RUB 10005, RUB 10013, and RUB 5000.
22 RUB 072.

34 Under the terms of the agreement the diocese remained responsible for the premises, property and buildings while the running of the house and its finances, together with the 250 acre farm, were the responsibility of the Brother Director. The Order was responsible for appointing the Brother Director and the brothers required to assist him. Provision was made for a chaplain to be appointed by the bishop. Apart from the chaplain, the Brother Director had power to appoint and discharge other officials 'with the sanction of the committee'.[23] The agreement required the Brother Director to keep audited accounts, and to submit a financial statement and general report to the committee of management each year. He was subject to a further restriction that the bank account of the home had to be operated by him and one other committee member.

35 Somewhat confusingly, the terminology used in annual reports and other documents thereafter does not precisely mirror the terminology of the agreement. There are references to the 'Governing Board' and not the 'Committee of Management', and later the term 'Board of Governors' was used. Since in the main the term 'Governing Board' was used that is the term we use in this report.

36 On 6 May 1950, BR 39 submitted an application to the MoHA for Rubane to be registered as a voluntary home for up to 70 children. In an accompanying letter BR 39 asked for financial support from the MoHA to make alterations and improvements to the buildings in Rubane to make them suitable for accommodating children.[24]

37 On 22 August 1950, the MoHA wrote to the Ministry of Education to confirm it was approving Rubane House as a children's home initially for 30 children, with the expectation that it would accommodate 60 children once it was fully operational. The MoHA also confirmed that it supported the proposed establishment of a voluntary primary school within the home.[25] The MoHA's decision to approve Rubane with the intention that in time it would accommodate 60 children is surprising, given the policy agenda that was being developed at that time for residential care of children in Northern Ireland. As referred to above, the Children and Young Persons Act (Northern Ireland) had come into force in 1950 and Voluntary Homes Regulations to support it were being developed and were

23 RUB 074.
24 RUB 10005 and 10007.
25 RUB 10015.

published in 1952.[26] In September of 1952 Home Office guidance on residential child care was circulated to all voluntary agencies providing such care in Northern Ireland.[27] The policy direction in this guidance, and in the legislation, and its associated regulations was towards giving priority to foster care and placing children in smaller children's homes where residential care was considered necessary. The Home Office guidance clearly disapproved of large homes and even contained an appendix with advice on breaking large homes up into smaller 'family' units.[28]

38 BR 39 had planned to initially accommodate 40 boys in Rubane. However, a note of a meeting that officials from the MoHA had with him in November 1950 records he was told that:

> "…on the basis of present arrangements, the number of boys to be accommodated should be up to a maximum of 30. Later on when further adaptations had been carried out consideration could be given to the question of raising the maximum."[29]

39 The first meeting of the governing board of Rubane House was held on 27 September 1950.[30] It was presided over by Dr.Mageean and attended by two Parish Priests and three priests from the Diocese appointed to the governing board by the Bishop. BR 19 the Irish Provincial at that time, BR 12 who was the first Brother Director of the Rubane community and BR 39 also attended the first meeting.

40 The membership of the governing board changed over the years but the chair was always the current Bishop of Down and Connor and the membership always consisted of De La Salle brothers and members of the clergy of the Diocese appointed by the bishop. When the bishop did not attend a meeting one of the senior clergy members chaired the meeting on his behalf.

41 The governing board met on 31 occasions from 1950 to 1985. The format for the meetings was that an annual general report and a financial statement for the preceding year from the Brother Director of Rubane were presented followed by a discussion of matters arising from these reports, identification of agreed action and approval of any related financial outlay.

26 HIA 287-291.
27 HIA 470-485.
28 SND 15708.
29 RUB 10020.
30 RUB 076/7.

42 It is clear from the minutes of the meetings that in line with the formal agreement between the diocese and the Order the focus was on practical matters to do with the establishment and development of the home, such as how the accommodation should be extended, funding applications, the management of the farm and the income achieved from it.

43 The copies of the annual general reports from Brother Directors that we have seen provide information about the occupancy levels in the home, but contain only brief and mostly positive comments about the direct care and condition of the boys. For example, the Annual General Report presented in February 1953 states:

> "...there is an excellent spirit among the boys who are very healthy and apparently very happy and content at Rubane. As the day's routine is well balanced as regards schooling, work and play this happy spirit is only to be expected."[31]

44 There are references in the annual general reports to visits from the MoHA and welfare authorities[32] but again these are brief and positive in tone and record officials expressing satisfaction with the health of the boys and appreciation of the work of the home. Although the Provincial or his assistant inspected the community, including the home, on an annual basis there are no references to the governing board receiving any feedback from these visits.

45 Therefore, it would appear that initially, in accordance with the agreement between the Diocese and the Order, the governing board was content to exercise its governance in relation to financial and practical matters and to leave the management and quality assurance of the care of the boys to the Order. However, as time goes on, it also considered and intervened in matters that had a direct bearing on the care of the children, such as the level of education that should be offered on site and the style of accommodation that should be provided.

46 At its meeting on 30 October 1951,[33] the governing board decided to establish a general purposes committee that would meet monthly to discuss any relevant matters that arose between the annual meetings of the governing board. The minutes of the governing board suggest it did not receive a formal report from the general purposes committee and

31 RUB 10868.
32 RUB 10868.
33 RUB 5178.

from the Inquiry's sight of a small number of minutes of meetings of that committee it appears to have focussed on immediate practical matters, such as agreeing repairs to the greenhouses and deciding on the type of livestock to be kept. However, the annual report to the governing board on 13 March 1957 records that three boys resident in Rubane "were sent directly by the General Purposes Committee".[34] The Order was asked if it could explain this entry and it confirmed that it does not believe the general purposes committee had a role in the admission or approval of admission of boys to Rubane. However, it explained that members of the general purposes committee had roles within parishes or organisations, such as the St Vincent de Paul, which may have assisted with admission arrangements and that such involvement may account for the use of this wording in the annual report.

47 The Order informed the Inquiry that the general purposes committee met frequently over a ten-year period but that over the passage of time it became increasingly difficult for it to "render regular and useful assistance and eventually it lapsed as an effective body".[35] We could only find minutes for preliminary meetings in January and February 1952, a meeting in April 1953 which was not quorate and a record of formal letters of appointment to the committee being issued to members of the committee on 11 June 1953.[36] However, there are references in the History of the Home/Important Events Book to meetings of the committee in March, April, May and September of 1955. This suggests that the general purposes committee played only a limited role in the oversight of Rubane for the first few years, and even that limited role appears to have ceased completely by the late 1950s.

48 The first brothers arrived to live and work in Rubane on 1 October 1950, BR 12 was Brother Director and supervisor of the farm and BR 23 was Prefect, the title the Order used for brothers who were responsible for the care of children rather than teaching them.[37] An opening ceremony for the Home was held on 15 December 1950[38] and on 8 January 1951 the MoHA formally issued a certificate registering Rubane House as a voluntary home.[39] This meant that the home could admit boys and could apply for government funding to improve its facilities, as under Section

34 RUB 10879.
35 RUB 019.
36 RUB 111-116.
37 RUB 11761.
38 RUB 11762.
39 RUB 10023.

118 (1) of the Children Act 1950 grants to voluntary homes could only be awarded for the improvement of existing homes, not the establishment of new homes.[40]

Expansion of Rubane House

49 The first group of 16 boys arrived on 17 January 1951.[41] Four were supported by welfare authorities, one by the Ministry of Pensions and one was a voluntary admission. The other ten boys were boarded out from St Patrick's and six of them had previously been resident in Nazareth Lodge.[42] The welfare authorities were, therefore, only responsible for the financial support of a third of the first group of boys placed in Rubane.

50 Because most of the boys had previously been voluntary admissions to Nazareth Lodge, the Order had to look to Catholic organisations to assist in financing their care. The Order depended heavily on contributions from the Diocese of Down and Connor Orphan Society Fund and the St Vincent de Paul Society (SVP); for example, during the years Rubane was in operation, the SVP contributed approximately £54,000 towards the maintenance of boys on voluntary placements. It also depended on the fundraising of the De La Salle Voluntary Workers Committee, formed by BR 39, which over time contributed approximately £49,000 to the maintenance of boys in Rubane.[43] The farm on the site was also a source of income and the Order informed us that up until 1972 approximately £55,000 of proceeds from the farm went towards the home.[44]

51 By October 1951 there were 34 boys in the home, three over the maximum limit set by the MoHA in November 1950. Twenty had been admitted from St Patrick's, three were voluntary admissions and eleven children were placed there by welfare authorities.[45] By December 1952 the number of boys had increased to 40, ranging in age from eight to fifteen years.[46] In 1953 the annual transfer of boys from Nazareth Lodge commenced with 26 boys being transferred[47] and by December 1953 there were 46 boys in residence.

40 RUB 10315.
41 RUB 11763.
42 RUB 10862.
43 RUB 017.
44 RUB 017.
45 RUB 10865.
46 RUB 10026.
47 RUB 11791.

52 Therefore, after almost three years in operation the home had admitted over 50 per cent more boys than the maximum limit originally set by the MoHA. The Inquiry has seen no correspondence or notes of meetings between the MoHA and the Order to indicate this increase in admissions was sanctioned by the Ministry. This willingness of the governing board and the Order to accept more boys than the home was approved to accommodate or had the facilities to deal with established a pattern of overcrowding that continued for the next seventeen years.

53 Part of the pressure to admit boys was due to the pressing need to reduce over-crowding in Nazareth Lodge. Ms Forrest of the MoHA reported in a note of her visit to Nazareth Lodge in November 1955 that children from that home were being sent to Australia because Rubane "can't absorb all their output".[48] It also seems reasonable to assume that the Order would have been reluctant to turn down requests from welfare authorities to accommodate Catholic boys who were the subjects of care orders if the alternative was that they would have to be accommodated in statutory homes.

54 A factor which significantly affected the number of boys admitted to Rubane emerged in January 1954 when the Ministry of Education wrote to the Order to ask whether boys from Rubane would be attending the new secondary school in Portaferry.[49] This school had been built because of recent legislation that required children of eleven years to move from primary schools to receive intermediate level education at secondary schools.

55 Brothers met with the Assistant Secretary of the Ministry of Education in February 1954 to discuss this requirement and its implications for Rubane.[50] In March 1954 the Down County Education Department wrote to the Order to clarify that since the school at Portaferry had no provision for educationally sub-normal (ESN) children, children in Rubane who had been assessed as ESN should continue to be taught there.[51] The Order brought this matter to the attention of the governing board at its meeting on 30 March 1954 and the governing board decided it would be better for all the boys in Rubane to continue to be educated on site and that BR 12 should seek to have the school at Rubane approved for the provision of intermediate level education.[52]

48 AUS 5160.
49 RUB 10080.
50 RUB 11797/9.
51 RUB 11324.
52 RUB 5184.

56 Although the provision of education is not a matter for this Inquiry, the decision to seek approval for the provision of Intermediate level education at Rubane is significant because the Ministry of Education stipulated that Rubane would only be considered for the provision of that level of education if it had a roll of 120 pupils. This meant that Rubane would have to be able to accommodate that number of boys, a number far in excess of that contemplated by the MoHA when it registered the home. These decisions to extend the schooling on the premises and admit a larger number of boys also meant that Rubane was being developed as a hybrid type of establishment: part children's home, part ESN boarding school and part training school.

57 While the number of boys admitted to Rubane was steadily increasing, the Order was engaged in negotiations with the MoHA about how the property might be renovated and extended to provide additional and more appropriate accommodation. The MoHA gave its support to an initial proposal from the Order to renovate the steward's house on the farm to accommodate a further 24 boys.[53] However, the governing board at its meeting on 3 February 1953 turned down this proposal because it considered that accommodation for a further 50 boys, not just 24 boys, was needed to address the overcrowding in Nazareth Lodge.[54]

58 On 6 June 1953 BR 12 met with representatives from the MoHA to discuss renovating the outbuildings at Rubane to create new accommodation that would enable up to forty boys to be transferred from Nazareth Lodge. The MoHA's note of this discussion[55] records general agreement that there was no satisfactory alternative to Rubane for the Nazareth Lodge boys and that it was not appropriate for them to be brought up exclusively under feminine influence, as they would be if they remained in Nazareth Lodge. The MoHA accepted that, in order to address the overcrowding in Nazareth Lodge, Rubane would have to be approved to accommodate a total of 80 boys. Although the rationale for this decision is understandable it was completely incompatible with the MoHA's recently stated and circulated policy in favour of smaller children's homes. We consider that the failure of the MoHA to insist from the outset that Rubane be developed on the smaller children's home model was a significant factor in bringing about the understaffing and unsatisfactory accommodation that contributed to the systemic failings we identify later in this chapter.

53 RUB 5180-5181.
54 RUB 5180-5181.
55 RUB 10067.

59 It is recorded that the MoHA representatives at the meeting indicated they were hopeful that some grants would become available for making improvements to voluntary homes, if the homes could show their inability to defray the costs themselves, and that they advised BR 12 to submit plans for the necessary renovations. On 11 June 1953 the governing board discussed options for providing additional accommodation.[56] On 6 July 1953 the MoHA wrote to BR 12 confirming its approval in principle to Rubane accommodating 80 boys, and saying it would consider a grant application towards the costs of the renovations once plans were submitted.[57]

60 BR 12 submitted plans for renovations in September 1953[58] and officials from MOHA visited Rubane on 25 March 1954 to discuss the building of a new wing.[59] However, the governing board decided at its meeting of 30 March 1954 to put the plans on hold in order to explore whether the accommodation should be developed along the lines of a cottage system, which would allow the boys to live in smaller groups.[60] This decision by the governing board was in line with the guidance given by the Home Office about breaking larger homes into smaller units.

61 At its next meeting on 25 April 1955[61] the Governing Board asked BR 12 to inquire into the cost of renovations to provide cottage style accommodation for the boys. At its next meeting in March 1956 the board of management was informed that there were 49 boys in residence and it agreed that a new house could be built for the chaplain in order that the accommodation he was using could be used to accommodate a further sixteen boys.[62]

62 BR 17 was appointed as the Brother Director in September 1956.[63] In his annual report to the governing board at its meeting in March 1957 he confirmed that the number of boys in residence had increased to 63 and that renovations had been completed to provide new accommodation for the chaplain and additional accommodation for "an extra dozen or so children".[64]

56 RUB 079.
57 RUB 10355.
58 RUB 10189 annotation at the top of the page.
59 RUB 10081.
60 RUB 5184/5.
61 RUB 5186-87.
62 RUB 10875.
63 RUB 10097.
64 RUB 10879.

63 Although the governing board put the plans for more extensive renovations on hold while the appropriateness of a cottage style system was explored, the Order appeared to take the MoHA's approval in principle that Rubane could accommodate 80 boys, once necessary renovations had been completed, as implicit permission to continue to increase the number of admissions. MoHA officials did not initially object to this increase; Dr Simpson and Ms Wright of MoHA inspected Rubane on 3 October 1957 and recorded that the steward's house was being used to accommodate 27 beds and that with the 44 beds available in the main house this meant Rubane now had a total of 71 beds.[65]

64 On 18 October 1957 BR 39 and BR 13 met with the MoHA officials to discuss possible grants for renovations in Rubane. MoHA officials record in their note of that meeting that without any grant from public funds the number of places available at Rubane had been increased from 30 to 71 places.[66] There is no suggestion of the MoHA approving this increase in admissions and no comment on whether the available accommodation was adequate for the increased number of boys.

65 The MoHA's willingness to give implicit approval to increased occupancy levels at Rubane appears to stem from the fact that the renovations undertaken to provide further accommodation had been paid for without the assistance of public funding. This reasoning, and the feelings behind it, were evident in a memo presumably from a senior civil servant (the signature on the memo is illegible) that was sent to the then Minister of Home Affairs, Walter Topping, to report on the meeting officials had with the Order on 18 October 1957. The author expressed frustration about the Catholic Church's unwillingness to give welfare homes a fair trial and aired his suspicion that the orders wanted to keep their numbers up so that funding for schooling provided alongside homes was maintained. He concluded the memo with the view:

> "I think the remedy lies with the Roman Church. If it is the determined policy of that Church to foster Voluntary Homes to the exclusion of the Welfare Authorities then they must be prepared to do so at their own expense."[67]

65 RUB 10201-10202.
66 RUB 10069.
67 RUB 10203.

66 It was only once officials found 78 boys in residence, when they inspected Rubane in October 1959,[68] that the MoHA intervened about occupancy levels. A terse letter was sent to BR 17 on 12 November 1959 stating that the numbers must be reduced to a limit of 71, the limit the MoHA had implicitly accepted during its inspection of the home in October 1975, and that he should ensure in future that that limit was not exceeded except for periods of a few days in cases of exceptional emergency.[69] Despite this letter, at the next inspection in April 1960 officials found that the number of boys had increased by one to 79.[70]

67 In December 1960, six and a half years after the governing board first discussed introducing a cottage system it agreed that plans should be progressed to introduce such accommodation together with a central dining room and kitchen.[71] This decision was followed by a prolonged series of discussions between the MoHA, the Order and the governing board about what renovations should be undertaken and what element of them might attract public funding in view of the Government's policy that funding would be granted towards the costs of building new accommodation to replace old buildings but would not be granted to increase occupancy levels. In a MoHA note about these discussions officials recorded:

> "...in recent years both we and the Ministry of Education have made many concessions as the need for improvements at Rubane became more urgent and the willingness and ability of managers to proceed with these improvements on their own more uncertain."[72]

68 While these negotiations were ongoing, the number of boys in Rubane continued to increase. In a letter of 7 February 1961 to the Provincial (which is unsigned but we assume is from BR 17) it is reported that 82 boys were residing in accommodation for 70 boys and six urgent cases were seeking admission. BR 17 described the accommodation as "bursting at the seams" and there being "intolerable congestion."[73]

69 By 1 September 1961 there were 86 boys living in Rubane.[74] In a memo to her seniors, Ms Forrest of the MoHA stated that improvements were needed to the facilities in Rubane to make them suitable to accommodate

68 RUB 10213.
69 RUB 10216.
70 RUB 10412/3.
71 RUB 10149, RUB 5198-9.
72 RUB 11943.
73 RUB 10116/7.
74 RUB 10292.

the existing supposed limit of 71 boys:

> "The present accommodation is unsuitable and inadequate for 71 in respect of cooking and dining, inadequate in respect of sleeping and sanitation and non-existent in respect of recreation."[75]

70 She explained in an appendix to her memo that in order to accommodate the 86 boys resident in Rubane:

> "…boys are sleeping in rooms previously used as drying and recreation rooms…the accommodation equates to holiday camp accommodation but is not suitable for permanent occupation."[76]

71 As a result of Ms Forrest's concerns, a further formal letter was sent to BR 17 on 6 September 1961 from Mr McGrath of the MoHA which stated he was directed by the Minister of Home Affairs to say no more admissions must be accepted to Rubane and no vacancies must be filled until the numbers were reduced to 71 boys. A hand-written note on the copy letter indicates that Mr McGrath spoke to BR 17 "to soften the blow" and let him know that Ms Forrest and Ms Wright would visit.[77]

72 In August 1962, there were significant changes in the governance of Rubane following the death of Dr Mageean. The new Bishop of Down and Connor, Dr Philbin, took over as chair of the governing board and BR 6 replaced BR 17 as the Brother Director.[78]

73 Just before he left Rubane, BR 17 wrote to the MoHA on 27 August 1962 to confirm that the governing board wished to build three chalets to house ten boys each, thereby bringing the available beds up to 100, and that the long-term plan was to eventually house all 100 boys in ten chalets.[79]

74 The need for the accommodation plans to be agreed and progressed was further highlighted when Ms Forrest and Ms Hill inspected Rubane on 14 November 1962 and found acute overcrowding in the dormitories. Five rooms contained 52 beds in the main house, and four rooms contained 31 beds in the steward's house: 83 beds in total, 81 of which were occupied.[80]

75 RUB 10291.
76 RUB 10292.
77 RUB 10295.
78 RUB 11821.
79 RUB 10155.
80 RUB 11869.

75 Overcrowding was not the only problem. Just as the accommodation had not been extended adequately to deal with the increased number of boys, neither had the staffing levels. Ms Forrest also recorded in her report of the inspection visit that there were seven brothers caring for 81 children, three of whom worked full-time as teachers and one who worked full-time on the farm plus a part-time matron. She contrasted these staffing levels with the Child Welfare Council's recommended staff child ratio of at least one member of staff to every six children aged over five years.[81] Implementation of that ratio in Rubane would have required the appointment of fourteen care staff, in addition to teachers and ancillary staff.

76 Following this inspection BR 39 and BR 6 were invited to a meeting in the MoHA where the need for improvements in the accommodation and in the staffing levels at Rubane was emphasised to them. The MoHA's note of this meeting records that the brothers expressed grave doubts about their ability to increase the staff ratio because the cost of renovations would stretch their resources.[82]

77 In February 1963, the MoHA responded to the proposals submitted by BR 17 to confirm it would be prepared to contribute to the cost of building three new chalets and to approve an occupancy level of 80 boys. It also indicated that the Department of Education would now be prepared to approve Rubane for the provision of intermediate level education if it achieved a roll of 80 boys.[83]

78 On 20 February 1963 the governing board met under the chairmanship of Bishop Philbin, and a number of grave doubts were aired concerning this proposal, including the excessive outlay, the supervision that could be provided in chalets and whether it would be possible to recruit housemothers. The governing board decided to set up a subcommittee to consider these matters in detail and to report back to it.[84]

79 Representatives from the governing board met with MoHA officials on 26 February 1963 to discuss their concerns, including their view that small bedrooms would provide opportunities for "undesirable practice"' between boys. They also made clear that the Order would not support brothers being replaced by care staff and working only as teachers; and, the

81 RUB Ibid.
82 RUB 10122.
83 RUB 10123.
84 RUB 5205.

diocese would not accept any lessening of the influence of the brothers. They asked the MoHA to consider contributing to the cost of building new large dormitory blocks rather than chalets.[85] The MoHA's note of this meeting recorded officials' surprise, and thinly veiled exasperation, at this proposal. It is recorded that officials pointed out to the representatives of the governing board that for the last eight years the discussions about extension to the accommodation at Rubane had always been on the basis of a chalet approach. Mr Parkes of the MoHA is recorded as saying that it would be unlikely the Ministry would fund developments it considered wrong, and that if the welfare authorities also considered the development of dormitory blocks was the wrong approach they might cease to use Rubane. He is recorded as going on to say that:

> "…it is doubtful if the Ministry would be justified in continuing to include in the Register of Voluntary Homes one which is staffed so inadequately at present."[86]

80 We assume this statement was an attempt to put pressure on the governing board to change its position about the planned accommodation. However, it is an important acknowledgement by the MoHA that it had the power to remove Rubane's registration and thereby its approval to operate as a children's home.

81 By September 1963 the governing board's plan had changed to building two cottages, each housing 20 boys in two dormitories.[87] Mr Parkes of the MoHA likened this proposal to a workhouse or an out-of-date training school.[88] In October 1963 he wrote to BR 6 and informed him that the plans could not be approved as they would not provide homely living arrangements for the boys. He also pointed out that the plans for staff accommodation did not suggest that the greatly-increased proportion of staff to children that the MoHA hoped for was included in the plans.[89]

BR 39 responded to this letter setting out the governing board's rationale for the proposal and although it is recorded in the "History of the Home" for 1963 that a number of meetings were held with MoHA officials to secure a grant for the proposed buildings no agreement was reached.[90]

85 RUB 10124-6, RUB 10141-6.
86 RUB 10125.
87 RUB 10306.
88 RUB 10307.
89 RUB 10127, RUB 11881.
90 RUB 11822.

82 On 14 November 1964 BR 6 wrote to the MoHA asking for the occupancy level in Rubane to be increased to 80 boys so that approval to offer intermediate level education could be achieved. Mr Parkes responded that the increase would be sanctioned, but only if agreement could be reached about plans for additional accommodation and assurances received that staffing levels would be improved.[91]

83 The description that BR 2 gave to the Inquiry about the conditions in Rubane when he arrived there in 1964 provides a good picture of how dire the environment was for the boys and the brothers while these prolonged discussions were going on:

> "Outwardly Rubane House itself gave an impression of stately grandeur but in reality it was rather primitive. Pre 1968 most of the boys were accommodated in the main House. The sleeping facilities consisted of four bedrooms upstairs containing ten beds in each. The five Brothers had a small single room each and one toilet and bathroom was shared by both boys and Brothers. On the ground floor there was another large bedroom used with one toilet for use of the boys and one Brother whose bedroom was close to the boys' room. There was no central heating in the house and heat was provided by a few electric heaters hung on the bedroom walls. The remainder of the boys slept in three rooms in the former farm manager's house at the bottom of the farmyard and were supervised by two Brothers whose bedrooms were located there. The kitchen and boys' dining room was located in the basement of the house as well as a common shower room. The conditions were sub-standard and Dickensian is the only word I can describe them. During meal times, the condensation was so bad that the walls were streaming with water. The laundry and clothing rooms were in an outhouse across the yard from the main house and on Friday/Saturday nights after showers, the boys had to run across the yard in their swim trunks and towels to get fresh clothing for the week. It seemed harsh at the time."[92]

BR 2 also commented:

> "The Home had as far as I am aware been inspected and approved by the Ministry of Home Affairs and they would have been aware of the extent and limitations of our facilities."[93]

91 RUB 11309, RUB 10167.
92 RUB 1036.
93 RUB 1036.

84 Finally during 1965 plans for cottage/chalet style accommodation were prepared and submitted to the MoHA followed by a formal funding application. In May 1967 the MoHA agreed to offer a grant of £50,000 towards the costs, subject to the amount being no more than 50% of the cost of the project and to a 40-year undertaking to repay the grant if the home were to close.[94] On 20 August 1968 the boys moved into the first chalets.[95] The second group of chalets was completed in March 1969 and in July 1970 78 boys were accommodated at Rubane.[96] This meant the home was operating within the approved occupancy limit of 80 boys.

85 The opening of the chalets heralded the introduction of lay care staff in Rubane. Although ancillary domestic staff had been employed from 1963, the care of the boys was exclusively provided by brothers until the chalets were opened. In 1968, two married couples, DL 134 and DL 135 and DL 303 and DL 115 and two nuns SR 32 and SR 57 were employed as house parents and SR 33 and DL 1 were employed as part-time care staff.[97] Despite this increase in staffing, BR 2, BR 3 and BR 11 had to continue to carry teaching and care duties; only BR 15 as a prefect was exclusively involved in the provision of care.

86 We consider that the persistent overcrowding, breaching of the approved occupancy numbers, inadequate accommodation and facilities and under-staffing which were allowed to continue in Rubane for seventeen years adversely affected the care and condition of the boys and the ability of the brothers to provide good quality care. Also, as we will consider later in this chapter, these conditions significantly contributed to the creation of an environment and culture that allowed the physical and sexual abuse of boys to occur and go unchecked.

87 **We consider that the MoHA, the Diocese as represented by the Governing Board and the Order contributed to a systemic failing to ensure the institution provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to continue for a decade while over-crowding increased and the facilities and staffing levels in Rubane became more inadequate and unsatisfactory.**

94 RUB 10444-10445.
95 RUB 10114.
96 RUB 10621.
97 RUB 11828.

88 **We also consider it a systemic failure in the governance arrangements for Rubane that while these prolonged discussions were ongoing the Governing Board only met annually and left the detailed negotiations to the Order.** While it expected the Order to conduct the negotiations with the MoHA it exercised its ultimate say and intervened late in the process to query an approach to the development of the home which had been planned and discussed for almost eight years. We do not accept that a change in personnel justified such a radical attempt to revert to an outdated and discredited view of child care accommodation.

89 We agreed with Father Bartlett's comments about the Diocese's role in these matters when he gave evidence to the Inquiry:

> "...having looked at that debate between the State and the church about the change of the type of care, it does strike me that the church was claiming a competence that it didn't necessarily have. I don't know on what basis the church could have claimed to be an expert on residential care of children other than from its experience of running boarding schools, for example, but that was not the particular environment that we were dealing with here."[98]

90 **We also consider that these prolonged discussions highlight a systemic failure by the Diocese, the Order and the MoHA as the registering body to clarify the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care.** In its submission to the Inquiry, the DHSSPS accepted that the MoHA did not engage sufficiently with the governing board.[99]

91 Improvements were made to the home from Rubane's own resources during this time, such as the renovation of outhouses in 1962 to provide a laundry and drying room and the decoration of bedrooms.[100] The brothers also built an outdoor swimming pool in 1959 with the help of the boys. However, these improvements were piecemeal in nature. We also noted that while the boys and the brothers were continuing to live in inadequate and overcrowded conditions resources were used to build two new bungalows, which were completed in May 1960 and occupied

98 Day 78, Page 17 Lines 2-14.
99 RUB 5964.
100 RUB 11822.

by a gardener and the woodwork teacher,[101] and that in the summer of 1961 the chapel was extended to provide a new sanctuary, choir wing and sacristy.[102]

92 Although the MoHA wrote to BR 17 on two occasions and met with BR 39 and BR 6 about the need to reduce the numbers it appears to have taken no effective follow-up action when the required reductions were not achieved. While we recognise that it would not have been easy to find accommodation for the large number of Catholic boys in Rubane at short notice we consider officials should and could have made more vigorous and assertive interventions to try and achieve improvements in staffing levels and accommodation than they did. For example, they could have summoned the chairman of the governing board and the Brother Director to Stormont to insist on a reduction in numbers and/or could have instructed the welfare authorities that no further admissions should be arranged until the numbers in Rubane reduced. In the ultimate analysis, the MoHA could have considered whether to withdraw the home's registration.

93 **We consider that the MoHA's willingness to allow the numbers in Rubane to more than double from 30 to 71 within six years without requiring the necessary improvements to the facilities or increases in staffing levels to be a systemic failing to ensure the institution provided proper care.** We accept that the MoHA was adhering to its policies for the administration of grants and understand why it was questioning the motivation for increasing the occupancy levels at Rubane. However, part of its acceptance of the increased occupancy levels appears to have been because they were achieved without State funding. We consider this attitude amounts to a dereliction of its responsibility to ensure that there were proper facilities for the boys in Rubane, as well as ensuring that conditions in the home were of a similar standard to those provided for children in homes in the statutory sector.

94 The number of placements funded by welfare authorities increased during this period, but we found no evidence of welfare authorities querying the facilities in Rubane or deciding not to send boys there because of the overcrowding. **We consider the welfare authorities' apparent willingness to place boys in facilities which were clearly inadequate and poorly staffed to be a systemic failing to ensure proper care.**

101 RUB 11819.
102 RUB 11820.

Inspection of Rubane

95 Another implication of the prolonged wait for improvements to the physical environment and staffing levels in Rubane is that these issues preoccupied MoHA officials when they inspected the home. It is clear from records and documents which the Inquiry has seen that officials from the MoHA maintained regular contact with Rubane House through formal inspections, formal and informal meetings and correspondence. It is also clear that the MoHA's officials' preoccupation with the physical environment in Rubane were grounded in concern for the boys. For example, it is recorded in the inspection report of 1962:

> "It was not an unusually cold day, but the damp chill of the basement wash-room was penetrating. Early morning ablutions in these conditions must be an endurance test."[103]

and the inspection report of 1965 recorded that the "premises militate against a warm and homely life for the boys".[104]

96 However, the focus on these practical matters meant that comments about the direct care and condition of the boys were limited and tended to be superficial.

97 In 1955 Ms Wright of MoHA and Dr Simpson of the Ministry of Health reported that all the children in Rubane were happy and responsive and without exception looked healthy and well nourished. They commented on the happy atmosphere in the home and that the relationship between staff and boys was excellent.[105] In the report of her 1956 inspection, Ms Wright reported a happy atmosphere in the home and that the boys she observed at play all appeared healthy and well cared for and enjoyed a good variety of indoor and outdoor activity.[106]

98 In 1957 Ms Wright reported she saw the boys in their classrooms and they all appeared healthy and well cared for and were looking forward to their annual holiday.[107] In 1958 Ms Wright and Dr Simpson recorded that they saw boys playing basket ball at the side of the house and they looked in good health and continued to enjoy a good variety of outdoor play activity.[108]

103 RUB 11869.
104 RUB 11870.
105 RUB 10191/4.
106 RUB 10195.
107 RUB 10201.
108 RUB 10204/5.

99 In 1959 Ms Wright and Dr Simpson commented on the educational level of some of the boys and how much the boys had enjoyed the new swimming pool during the previous summer period.[109]

100 There are two references in inspection reports we have seen to the use of corporal punishment. In May 1955 Ms Forrest reported that corporal punishment was only occasionally inflicted and none had so far been recorded in that year. In April 1956 Ms Wright reported that several cases of corporal punishment had been recorded, mainly for absconding.

101 There are some examples of more critical comments about the care and condition of the boys. For example, in 1962 Ms Forrest and Ms Hill reported that although all the boys were in good health and relaxing after school:

> "…many looked pinched and cold; their clothing in many instances was in very bad order, threadbare and torn, and affording little protection against the weather."[110]

102 In the reports of all these inspections, alongside the brief observations about the boys there is much more detail about overcrowding, staffing levels and planned renovations. As we will consider later in this chapter, witnesses who were resident in Rubane during the time of these inspections gave consistent accounts to us of a harsh regime of chastisement and physical and sexual abuse by certain brothers. It may be that if the inspectors had been less preoccupied with the need for physical improvements and had spent more time considering the care the boys were receiving and talking directly to them this abuse could have been uncovered. We recognise that boys may have been too unsure of inspectors who were not regular visitors to confide in them and may have been scared of possible repercussions from the brothers. It may also be the case that the implicit trust placed in faith-based care would have prevented inspectors questioning the work and conduct of the brothers. However, it is our view that the preoccupation with practical matters meant that opportunities for closer inspection of the quality of care provided in Rubane were lost.

Adherence to regulations

103 The Children and Young Persons (Northern Ireland) Act 1950 and the Regulations issued to support its implementation, the Children and Young

109 RUB 10213/4.
110 RUB 11869.

Persons (Voluntary Homes) Regulations (Northern Ireland) 1952[111] set requirements to be met by the "administering authority" of homes, which was defined in Regulation 3 (1) as "the person or persons carrying on the voluntary home". Regulation 4 (2) was one of the most important of these regulations in relation to the care and welfare of children in voluntary homes. It required:

> "The administering authority shall make arrangements for the home to be visited at least once in every month by a person who shall satisfy himself whether the home is conducted in the interests of the well-being of the children, and shall report to the administering authority upon his visit and shall enter in the record book referred to in the Schedule hereto his name and the date of his visit."[112]

104 This requirement was intended to provide an external presence to monitor and observe the care being provided for children. It was important and not a formality, because as Dr Harrison pointed out in her evidence:

> "…the purpose of those visits was particularly within the regulations to report on the welfare of children. Now you could not do that without seeing children and being aware of their general or physical appearance even if they -- even if they are not engaging with you in conversation, but, you know, you would certainly be aware of the physical appearance of the children."[113]

105 Despite the importance of this regulation and its statutory basis the first attempt at introducing a monthly visitor in Rubane was made in 1978, 26 years after the regulation came into force.

106 We concluded that the primary reason for this lack of adherence was that while the regulations envisaged one administering authority for each home the operational and governance arrangements in Rubane meant that responsibilities were shared between the Diocese and the Order. As previously explained the Diocese asked the Order to run the home on its behalf and the subsequent agreement that it entered into with the Order in 1950 specified that whilst the Diocese remained responsible for the premises, property and buildings, the Order would provide the staff and appoint the Brother Director who would be responsible for the day to day running of the home.

111 HIA 288.
112 HIA 288.
113 Day 77, pages 164 – 165.

107 From the beginning, the Order took the lead in communications and negotiations with the MoHA; it was BR 39 who made the application to the Ministry in May 1950 that the home be registered under the 1950 Act. In the accompanying form it was "The De La Salle Brothers, Milltown" who were described as the "organisation or society in charge", and BR 39 was named as "the person in charge of the home".[114] Almost invariably, it was the Brother Director who dealt directly with the MoHA over the many matters relating to the running of the home, particularly regarding the number of boys in the home and financial support in the form of grants. The Order accepts this and acknowledged in its evidence to the Inquiry that

> "…it had day to day control of operations on the ground and was therefore the only organisation who could actually comply with many of the [1952] regulations on a practical level".[115]

108 The regulations placed responsibility on the administering authority to appoint "a person to be in charge of the home" (Regulation 5 (1)) and placed responsibility on the officer in charge to ensure the home was conducted from day to day in such a way as to "further the wellbeing of the children in the home". The Order accepted in its evidence to the Inquiry that "The Director was effectively the 'officer in charge'.[116] Therefore in its appointment of the Brother Director it was fulfilling an important aspect of the role of the administering authority. The order asserted in its evidence to the Inquiry that appointments to the position of Brother Director were subject to the approval of the bishop. However, no evidence to that effect has been produced, and the need for such approval would have been incompatible with the 1950 Agreement.

109 The importance of the position of officer in charge was underlined by Regulation 15, which required the administering authority to notify the Ministry when the person in charge of the home ceased to be in charge of that home and a new appointment was made. Again it was the Order that met this responsibility of the administering authority and informed the MoHA of changes of Brother Director.[117]

110 Although it met these aspects of the responsibilities of the role of the administering authority the Order's position is that it ran the home at the request of, and for the purposes of, the Diocese, and it operated under a

114 RUB 10007.
115 RUB 1179.
116 RUB 015.
117 RUB 11187 and RUB 11188.

degree of supervision of the Diocese through the governing board and in time the management committee. Therefore, the Order asserts since the bishop had overall responsibility for the home he was the "administering authority" and so it was the Diocese that was "carrying on" the home.[118]

111 We agree that, despite the Order fulfilling aspects of the role of the administering authority, the ultimate control over the home remained with the Diocese throughout. The Diocese retained overall responsibility for the governance of the home and the governing board did not reserve its authority to matters to do with the premises, property and buildings as per the agreement. For example, at its fifth meeting it took the decision in principle to admit boys from welfare authorities and to charge a £3 a week maintenance fee for such placements.[119] It had the decisive voice in many areas of the running of the home. A notable example of this was the intervention of the Diocese in February 1963[120] at a very late stage in protracted discussions between the MoHA and the Order in an attempt to prevent the creation of chalet-style accommodation for the boys. Another example was the suspension of the Brother Director, BR 1, by the bishop in 1980 and the ultimate exercise of its authority was the governing board's decision in 1985 that Rubane should cease to operate as a children's home.[121]

112 In its evidence to the Inquiry, the Diocese acknowledged its responsibilities in this regard and accepted that it was the administering authority throughout Rubane's existence. However, Fr Bartlett also referred to the Diocese and the Order being "joint administering authorities" wherein neither the Diocese nor the De La Salle congregation were in a position of sole control.[122] We consider that this is a more accurate description of the actual arrangements.

113 We could find no evidence of the governing board or the Order considering what implications the regulations had for the dual structure in place in Rubane where responsibility and control were jointly exercised by the Diocese and the Order. The first meeting of the governing board after the publication of the regulations took place on 3 February 1953 and there is no reference in the minutes of that meeting to the regulations and therefore no

118 RUB 1178/9.
119 RUB 5182-5183.
120 RUB 5205.
121 RUB 5241/3.
122 RUB 5915.

attempt to clarify who was the authorising authority or how the associated responsibilities, including the appointment of the monthly visitor, would be met. **We consider that the Diocese and the Order had shared responsibility to pay proper regard to and meet statutory regulations, clarify who was the administering authority for Rubane, and appoint a monthly visitor, and that they both failed to meet that responsibility.**

114 This situation could have been rectified if the MoHA, through its inspections of the home, had sought clarity in relation to who was acting as the administering authority and enforced the statutory requirement for appointment of a monthly visitor. However, we have seen no reference to the administering authority in inspection reports of Rubane and only one reference related to monthly visiting. The report of the inspection of Rubane House undertaken by Ms Wright and Dr Simpson in 1955 was presented in a pro forma style with set headings that specified what matters should be reported on.[123] This contrasts with the other reports of the inspections carried out by MoHA officials in Rubane that we have seen which are in the form of internal memos, some of them handwritten. As part of the pro forma used in 1955, inspectors were asked to report on the work of visiting committees.

115 Under this section of the pro forma Ms Wright and Dr Simpson recorded that there was a board of management but no visiting committee.[124] There is no further comment on whether the board of management was undertaking the role of a visiting committee, or whether the lack of such a committee and thereby the failure to appoint a monthly visitor was discussed with the brothers or the governing board. Ms Wright inspected Rubane the following year and there is no indication in her report, which reverted to a free-style format, that she raised the lack of a monthly visitor in that inspection. In later years when SWAG undertook inspections of voluntary children's homes they used a more standardised approach to inspections and reporting on findings. However, although monthly visiting was retained as a requirement when the regulations were revised in 1975, we found no evidence of SWAG inspectors monitoring adherence to it. **We consider this lack of enforcement of statutory regulations to be a systemic failing by the MoHA and its successor bodies to properly promote and enforce government policy and to ensure that Rubane provided proper care.**

123 RUB 10191/4.
124 RUB 10193.

116 In its closing submission to the module the DHSSPS accepted this failing:

> "It has been acknowledged above that the administering authority whatever its identity, did not comply with Regulation 4 of the 1952 Regulations. Equally, it is recognised that there was a duty upon the Department to ensure that there was such compliance and that the Department failed to discharge that duty. Even as late as 1981 when the Social Work Advisory Group undertook an in-depth investigation at Rubane, the failure of the administering authority to carry out its obligations under the 1952 Regulations was not recognised or noted."[125]

117 We agree with Dr Hilary Harrison's acknowledgement in her statement on behalf of the DHSSPS that officials' failure to ensure that statutory requirements were being met and to engage with the governing board were shortcomings that are likely to have "contributed to a system that failed a significant number of children".[126]

118 The failure to appoint a monthly visitor removed a crucial part of the mechanism that was designed to provide regular external monitoring of the standard of child care being provided in the home. **We consider that the failure for many years by the MoHA, the Diocese and the Order to make sure that monthly visiting as required by the Regulations was taking place amounts to a systemic failing by each of them to ensure that the home provided proper care.**

119 It was not until 1978 and the establishment of a management committee that some attempts were made to establish monthly visiting.

Management committee

120 With the demise of the general purposes committee in approximately 1961 there was a period of approximately seventeen years when the Diocese's contribution to the formal governance of Rubane was limited to its chairing and membership of the governing board. However, this changed significantly when the governing board decided at its meeting in November 1978 to approve the establishment of a management committee.[127]

125 RUB 9312/3.
126 RUB 5964.
127 RUB 5229.

121 The minutes of that meeting recorded that the management committee was to be entirely advisory and "to act as a back up to the Brother Director in any difficulties that might arise." However, in its statement to us the Order indicated that the management committee's role was both executive and advisory and that its primary function was "to supervise the management of the Home and to advise the Officer in Charge in all matters pertaining thereto."[128] We are of the view that whatever the original intention, the minutes of the management committee record a level of involvement in the running of the home that went well beyond the provision of advice and that the committee took on an executive and supervisory role.

122 The first meeting of the management committee was held on 5 February 1979;[129] it was chaired by Very Reverend McCann and the other members were Very Reverend Kevin Donnelly PP, Very Reverend Hugh Starkey PP, Rev John O'Connor, Mrs Mary Nihill, a lay magistrate of long years standing in the juvenile courts of summary jurisdiction in Northern Ireland. At the first meeting Mrs Nihill was appointed vice chairman of the committee and BR 6 was appointed as secretary.

123 The Order told the Inquiry that the management committee was responsible to the governing board and that it met a minimum of six times a year. However, we found no evidence of a formal reporting line between the governing board and the management committee; there was no record of the management committee submitting its minutes or a report of its work to the annual meetings of the governing board.

124 Also, from the Inquiry's review of the minutes of the committee it appears that it only met six times in 1980. It met five times in 1979, 1982 and 1983, four times in 1981 and 1984 and three times in 1985. The final and 32nd meeting of the committee was held on 29 April 1985.

125 In contrast to the governing board and the general purposes committee the management committee did concern itself with the quality of the care being provided to the boys. At its first meeting, Father O'Connor was asked to outline the most important functions of children's homes and he emphasised the need for a child-centred approach and for the quality of care to be analysed and constantly kept under review. He also spoke of the importance of the Catholic voluntary sector being able to offer a service as good if not better that that provided in state institutions.[130]

128 RUB 019.
129 RUB 5232.
130 RUB 11033.

126 It is clear from the minutes of the meetings of the management committee that its focus on ensuring the quality of care was on supporting and monitoring the performance of lay care staff. The committee was responsible for setting the terms and conditions of service for these staff, assisting in their appointment and deciding whether they had successfully completed their probationary periods. It intervened directly in matters to do with discipline of lay staff and their grievances, however the appointment of brothers and the allocation and management of their work continued to be a matter for the Order. This appears to stem from the dual structure for governance of Rubane created by the agreement between the Diocese and the Order. We are of the view that this was an unsatisfactory arrangement and that the whole of the management of the home should have been in the purview of the management committee, even if the Order allocated the brothers to work in Rubane.

127 It was at its third meeting on 29 May 1979[131] that the committee agreed that between meetings members should make informal visits to the home, speak to staff and inspect various parts of the building. At its next meeting, on 11 September 1979,[132] the vice chairman reported back on her visit to inspect the kitchens and the committee agreed that it would be impressed on staff that they should feel free to approach members of the committee at any time and that any points they wished to raise would be given the greatest sympathy and understanding. We noted that there is no reference at this time to the boys being told that they should feel free to approach the management committee members.

128 The management committee only received three further reports of visits. Mrs Nihill reported in November 1979[133] on her visit to inspect the sleeping accommodation and wash areas and in November 1980[134] about her second visit to the kitchens. Father McCann, Father Donnelly and Mrs Nihill reported to the committee at its meeting on 5 April 1982 on what they described as an inspection they had undertaken of the chalets.[135] Mrs Nihill's reports of her visits indicate that she focused on the adequacy of the facilities while the report of the inspection of the chalets records that the three committee members met with staff in the chalets and discussed their work with them. There is no mention in any of these reports of

131 RUB 11036.
132 RUB 11038.
133 RUB 11043.
134 RUB 11053.
135 RUB 11073.

committee members meeting with or observing the boys. However, during the inspection of the chalets DL 11 raised the issue of his time with his family in his private quarters being disturbed by the level of noise coming from the boys' quarters and the committee subsequently decided that residential staff should be asked to seek outside accommodation in the best interests of the children of the home.

129 A two-year gap followed before any more formal visits were arranged. However, we accept the evidence from the Order that management committee members and in particular the chairman of the committee visited Rubane regularly between committee meetings, although this was primarily to meet with staff. In May 1984 the management committee made a second attempt to introduce regular visits to the home. The minutes of its meeting on 8 May 1984 record that "in the spirit of the Monitoring of Residential Care Service in the Home", a member should be appointed to make regular visitation in a formal and voluntary capacity. This time the committee agreed that the boys as well as the staff should be made aware of the visits and told they would have free access to the visitor and could "make known their wants or air any matter of grievance."[136]

130 The commencement of these visits was delayed because the vice chairman, Mrs Nihill, who was selected to carry out the visits, subsequently resigned from the management committee and it took some time until her replacement, Mrs Keating, joined the committee. Mrs Keating visited the chalets on 26 and 28 February 1985 and reported to the Committee at its meeting in March 1985, that she met with ten boys and told them that:

> "...they should feel free to approach her on anything that might be preying on their minds, any complaints, request or suggestions they would like to make."[137]

The Committee agreed that in order to facilitate the boys' access to Mrs Keating she would visit on the first Tuesday of every month. It is also recorded at that meeting that the parish priest and curate had agreed to pass on to the committee any complaint which the boys might convey to them.

131 These arrangements were being put in place 33 years after the regulation requiring monthly visits was introduced. Mr Bunting, who was an assistant director in the Eastern Health and Social Services Board (EHSSB) in the

136 RUB 11092.
137 RUB 11101.

1980s, spoke in his evidence to the Inquiry about the value of monthly visiting and how it provided safeguards for the children resident in statutory homes run by the EHSSB.[138] Given that some of the children in Rubane had no families, and a number of witnesses referred to the difficulties their family members faced in visiting Rubane because of its isolated location, it would have been particularly valuable if regular monthly monitoring visits to Rubane focussing on the wellbeing of the children had taken place.

132 We cannot say what difference monthly visits would have made in Rubane or whether the boys would have been willing to engage with a visitor and would have been better protected through doing so. However, there is no doubt that a regulatory measure introduced to promote the wellbeing of children and increase their protection was not implemented in Rubane as it should have been.

Falling intakes to Rubane House

133 Although the management committee focused on the provision of care in Rubane it also had to concentrate from its first meeting on the falling intakes to Rubane and the implications this had for the continued viability of the home.

134 In July 1971 BR 2 had been promoted to the role of Brother Director in Rubane.[139] While previous Brother Directors oversaw steady increases in the number of boys admitted to Rubane, BR 2 had to deal with declining numbers while trying to reduce the debts incurred through the building of the new chalets.

135 Over the years, the number of boys placed in Rubane by welfare authorities had steadily increased and in his new role BR 2 decided to ask relevant welfare authorities to take on the support of the remaining twenty boys who had been placed in Rubane on a voluntary basis. He explained in a letter to a colleague in October 1973 that he took this step because of the burden of repaying the debt incurred through the renovation work and building of the chalets and the increased costs of maintaining the property. He explained that the welfare authorities' agreement to support the children meant that "the financial worries have eased considerably".[140]

138 Day 77, pp. 131-134.
139 RUB 11834.
140 RUB 10591.

136 We noted that Mr Bunting in a memo of 29 December 1971 to the city welfare officer about this matter advised that financial responsibility should be taken on for the boys, but with two important provisos: firstly, that the boys' files would be provided so that contact could be made with any families they might have and the possibility of rehabilitation explored; and, secondly, that it was made clear to the Order that future placements would have to be agreed in advance and that it would not be acceptable for the Order to accept voluntary placements and then expect the welfare authorities to fund them.[141] We consider it good practice that the welfare authorities were keen to prevent unnecessary admissions of children into care and wanted to be able to consider the circumstances of children and their families and whether other interventions might be possible.

137 The contribution of weekly maintenance fees from welfare authorities was very significant for the home's budget. Therefore, when reducing occupancy meant higher per capita costs it was necessary to ask for sharp increases in weekly fees. This meant that following modest increases from 1951 to 1971, the weekly fees were increased considerably in the next four and a half years, rising from £6 to £35.

138 By April 1973 there were only 60 boys in residence, although later that year the figures increased again and peaked at 80. However, by April 1974 the numbers had decreased to 69[142] and by September 1974 they had further decreased to 60 boys.[143]

139 The responsibility for the registration and regulation of voluntary homes for children transferred to the DHSS in January 1974 and it asked homes to review and confirm their occupancy limits. In recognition of the falling admissions, BR 2 responded and advised that the accommodation limit for Rubane should be reduced from 80 to 70.[144]

140 By December 1975 the regular annual transfer of approximately twelve boys from Nazareth Lodge to Rubane had stopped because Nazareth Lodge had developed the service it offered to enable family groups to stay together and children to have a stable placement in one home for as long as they needed residential care. This change had a significant impact on the numbers admitted to Rubane and by December 1976 the numbers had fallen to 46 and, as a result, one of the chalets was closed.

141 RUB 5670.
142 RUB 10635-10636.
143 RUB 10239.
144 RUB 10169.

141 The ending of the transfer of boys from Nazareth Lodge to Rubane also affected the length of time boys were staying in Rubane. Boys admitted from Nazareth Lodge were aged around eleven years and stayed typically four or five years, whereas from around 1975 onwards older boys admitted from the community typically stayed one or two years.

142 In addition to the impact of the changes in Nazareth Lodge there were a number of other policies that contributed to the reduction in admissions to Rubane. These included: an increased preference for fostering and smaller more family orientated homes; a greater emphasis on accommodating and caring for siblings together; and, residential care being increasingly used for brief placements to enable specific difficulties in a child's life to be addressed and to provide brief respite while foster care or return home was planned. NL 191, a social worker who gave evidence in Module 4, was involved in placing and supporting children in Rubane at this time. She confirmed that Rubane was seen as a holding place for short stays, often when an urgent admission was required under a Place of Safety Order and that the aim was to get boys in and out as soon as possible.[145]

143 There was also a marked increase in the number of places available in statutory residential children's homes in Northern Ireland; between 1973 and 1981 these increased from 121 to 527.[146] Welfare authorities began to fill places in statutory homes first to ensure full usage of local provision but also to enable children to be cared for as close to their own homes as possible. The management committee in Rubane commented on these developments at its meeting of 6 October 1980 and recorded its view that voluntary homes were under threat due in part to social workers disregarding the wishes of parents in deciding upon placements:

> "Religion seems to be of minor importance. What appears to be important is the filling of the Statutory Homes."[147]

144 Despite this view we saw evidence of the EHSSB supporting the work in Rubane. For example, on 16 June 1980 Mr Bunting wrote to Fr McCann and told him that the EHSSB was raising the salaries of residential child care workers and was prepared to increase the weekly maintenance fees paid to Rubane in order to enable it to offer a similar increase in salary to its staff.[148]

145 Day 105 25 March 2015 Page 23.
146 RUB 11151.
147 RUB 11051.
148 RUB 5734.

145 The use of Rubane continued to decrease and by 1980 two of the chalets were closed and there was growing anxiety about the viability of the home. By September 1981 the numbers had reduced to 29 and in 1982 the numbers ranged from 28 to 32.[149]

Regulatory activity in later years

146 In contrast to the regular contact that the MoHA had maintained with Rubane there was much less regulatory activity in the 1970s. The Social Work Advisory Group (SWAG) inspected Rubane in September 1973, August 1974, October/December 1975 and July 1976 and in addition in February 1975 Mr Robert Mills, then Assistant Secretary with child care responsibilities in the DHSS, visited Rubane. However, there was no official inspection of Rubane by SWAG or the Department between 1976 and March 1981. This lack of inspection meant that children in Rubane at that time did not receive the benefit of regulatory measures intended to protect the welfare of children and quality assure the care they received in voluntary children's homes.

147 The Hughes Inquiry found that the absence of formal inspection between 1976 and March 1981 was unsatisfactory and that the inspections carried out in the 1970s as a means of gaining a genuine insight into the standards of care in Rubane were inadequate. The Department did not challenge these findings by the Hughes Inquiry. We agree with the Hughes Inquiry findings and **we consider that this lack of inspection activity between 1976 and 1981 and the inadequate nature of the inspections in the 1970s amount to a systemic failing by the Department to ensure the institution was providing proper care.**

148 Correspondence in January 1981 from Mr Wilde, the Chief Social Work Adviser in the DHSS, to Mr Gilliland, Director of EHSSB,[150] shows that the management committee of Rubane were proactive in seeking to engage with the DHSS as the regulatory body for the home. Mr Wilde states in this letter that officials from the DHSS would soon be meeting with representatives from the management committee of Rubane at their request:

> "...when issues about the aims, objectives and no doubt child care practices in the Home will arise."

149 RUB 11109.
150 RUB 5758.

149 Before turning to consider the inspection activity that emerges from that meeting, it is worth commenting on the background to the letter referred to above as it illustrates tensions in the relationship between the DHSS and the Health and Social Services Boards about the regulation of voluntary homes. As we have noted in earlier chapters, there were tensions between the MoHA and welfare authorities because the welfare authorities resented having to contribute to the cost of grants to voluntary homes when they were not given the opportunity to influence the admissions policies of these Homes or how they were run, and were given no access to the outcomes of the MoHA's monitoring of the quality of care provided in the homes.

150 In 1981 the tension was no longer about funding but about who was responsible for quality assuring voluntary children's homes and dealing with complaints that emerged about child care practices within such homes. The background to Mr Wilde's letter to Mr Gilliland was that Mr Gilliland had written to Mr Wilde in November 1980 highlighting concerns that a social worker in his Board had raised with her senior managers about general aspects of the care practices in Rubane, including the quality of the clothing provided to the children and the rigid approach to the daily routine. Mr Wilde responded in December 1980 by querying the basis for the social worker's concerns, whether she had discussed them with the Brother Director of Rubane, BR 2, or his deputy and what policies and procedures the Board had for investigating complaints from children in their care.

151 The letter of January 1981 referred to above is a follow-on from this letter and in it Mr Wilde stated that he wanted to make clear that:

> "…the Department's registration and inspectorial functions do not in any way diminish the responsibility of Boards to actively pursue the needs of individual children in their care who are accommodated in voluntary homes with appropriate senior staff, or if need be, with the Management Committee of the Home concerned".[151]

Although, Mr Wilde ended his letter with the request that the DHSS be informed if it did not prove possible for the Board to resolve problems with Rubane we consider that this approach by the DHSS could be seen as a shirking of its responsibilities for regulating the quality of voluntary homes. We consider that investigation of general matters which affected children

151 RUB 5758.

placed in the home by more than one welfare authority, and which would have entailed questioning of senior staff and reference to the governing body of the home, to be of a different order to a social worker seeking to address specific issues about a particular child.

152 In our view, the Eastern Board was appropriately raising concerns about general practices in Rubane that might affect all the boys resident there, not just those boys for whom it was responsible and the DHSS was attempting to place what amounted to an inspection role on the Board – a role which it did not have the powers to perform. It was the DHSS that had the responsibility to assure itself of the quality of overall care provided to children in Rubane and in other voluntary children's homes in Northern Ireland and it was the only body with the statutory authority and powers to meet that responsibility. **We consider the DHSS failed to properly respond to the concerns raised by the Eastern Board in 1981 about the general care being provided to all boys in Rubane and that this amounts to a systemic failure by the DHSS to ensure that the home was providing proper care.**

153 The engagement of Rubane Management Committee with the DHSS resulted in an inspection of Rubane carried out by the Child Care Advisory Board of the DHSS in March 1981. The introduction to the report of that inspection states that recent departmental policy provided for a more detailed inspection of children's facilities and that Rubane's management committee had also been asking for an evaluation of the home's performance and of its current functions to facilitate planning for possible changes.

154 The inspection was carried out over a five-day period and involved four inspectors. Three of the inspectors spent an evening with boys in one of the chalets and talked and shared a meal with them.

155 A 31-page report of the inspection[152] was produced and shared with the staff and the management committee of Rubane. Although attention continued to be paid in the inspection report to physical amenities, occupancy levels, staffing and finance issues, there was more comment on the quality of the direct care provided to the boys and suggestions about how it could be improved. For example, it was reported that the inspectors found some staff to be advocates of routine management of the boys, with an emphasis on discipline and sanctions, and that they

152 RUB 10245-10278.

seemed to concentrate more on activities and to be less responsive to the individual needs of the children. The regimented approach to leisure time, with an emphasis on compulsory and organised activities for boys and use of frequent line up and confinement in the yard at certain times, was also commented on. Inspectors recommended that staff should be encouraged to consider the aims and objectives of their work and how to provide for the needs of individual boys constructively instead of thinking in the negative terms of applying sanctions.

156 Inspectors also commented on the ratio of staff to boys and the range and load of duties staff and, in particular, brothers were expected to carry and how this could have an impact on the care of the boys:

> "Fatigue brought about by long hours of duty can cause staff to become less sensitive to the needs and demands of those in their care. In turn this can lead to less effective work and allegations of unprofessional behaviour."[153]

157 The report concluded by suggesting that the management committee would need to consider its future policy and a possible change in the function of Rubane.[154] This is the first example we have seen of the DHSS beginning to engage with Rubane about the implications of the changing policy context for residential care of children and the reducing place for large homes.

158 We noted that inspectors did not pick up on the lack of monthly visiting and although they identified that Rubane had not submitted a required return about the use of corporal punishment to the Department in 1980 the submission of such returns was not included in the recommendations set out at the end of the inspection report. We consider these oversights to be a further example of a systemic failure by the Department to enforce statutory regulations. We also noted that very significant challenges facing Rubane, which we will consider later in this chapter, including the suspension of staff following allegations of abuse, are given the briefest mention in the report and there is no indication that inspectors had confidential discussions about the implications of them with the management committee or the governing board.

153 RUB 10260.
154 RUB 10277.

159 The report was considered by the management committee on 28 September 1981[155] and the minutes of that meeting record that the committee read passages of the report with almost incredulity, if not dismay, and expressed:

> "…amazement at the paucity of praise given to many positive qualities which the Home undoubtedly possesses".

and noted:

> "Why is a home which down through the years had given the Community efficient and faithful service, and which had earned high commendation from officials of the Home Affairs and Education, should suddenly be considered almost obsolete, was difficult to comprehend."[156]

160 The reactions of the management committee of Rubane and the staff to the inspection report were also recorded in the History of the Home for 1981.

> "They published their report later in the year, and their conclusions in general were far from acceptable to either the staff of the Home or to the Management Committee. Their recommendations were quite acceptable and positive and were easily enough implemented, but various statements in the body of the report were regarded as less than fair or just towards the work being done in the Home, at present, and over the past 30 years."[157]

161 The management committee asked BR 2 to draft a response to the report and this led to a meeting between the committee and officials from the DHSS on 19 November 1981. It is recorded in the "History of the Home" that:

> "The Advisory Board Team tried to point out that they did not in any way try to cast suspicions on the quality of care being provided for the children. They were only trying to pinpoint certain areas, where perhaps some change, or a different attitude could be taken in the interests of all concerned."[158]

162 The minutes of the management committee record that the tone of the meeting with officials had been conciliatory but also note that officials had pointed out that its policy was for children to be reared, as far as possible,

155 RUB 11061.
156 RUB 11063.
157 RUB 11854.
158 RUB 11854/5.

within their own community boundaries and that there was an oversupply of residential care provision.[159]

Embargo by the Eastern Health and Social Services Board

163 In the context of falling numbers, and a policy direction which militated against the use of Rubane, the home's position was particularly precarious because its reputation had been damaged from 1980 onwards by allegations of physical and sexual abuse against staff and reports from lay staff about poor child care practice and management in the home, which came to the attention of the welfare authorities, the DHSS and the police. We will consider these matters in detail later in this chapter.

164 In February 1982, concerns about care practices in Rubane led the EHSSB, which at that time was the biggest single user of the home, to place an embargo on boys from its area being placed in Rubane. In the minutes of the management committee meeting held on 12 October 1982[160] there is a reference to committee members meeting with representatives from the EHSSB and officials from DHSS to discuss the Board's embargo and that members came away from the meeting with a certain amount of pessimism. There is also reference to a further meeting on 5 May 1982 between the committee and the representatives of the four Area Boards and it is recorded that members felt "a veiled hostility was in evidence though some of the Boards were supportive of the Home".[161] Although the embargo was lifted in August 1982, confidence in Rubane had clearly been damaged by it.

165 In October 1984 Father John Connor, a member of the management committee and director of the Down and Connor Family Welfare Society provided a very damning report about Rubane,[162] which we assume, given its content, was for Bishop Philbin. He began his report by setting out the changing policy context for care of children, the move away from residential care and the reduction in the use of voluntary homes and increased use of statutory provision. He then made the point that to continue to "exist meaningfully" in the midst of such change a voluntary home would need to be prepared to adapt and that in his view Rubane had neither the capacity

159 RUB 11066.
160 RUB 11074.
161 RUB 11074.
162 RUB 11153.

nor the will to change. He stated that the quality of child care in Rubane was not good enough and that efforts by the management committee and by him and his staff to encourage and support the brothers to improve child care in Rubane had been met with resistance and proved fruitless. He concluded that in the present child care climate it would merely be a matter of time before the home would have to close and that "the Diocese would be best served by cutting its losses and closing the home".[163]

166 It appears this advice was accepted, because a meeting of the board of governors was convened on 30 March 1985 and it decided that Rubane was no longer viable and should close.[164]

167 We note that this meeting of the governing board was the first time it had met since 1982. As referred to previously, the governing body met on 31 occasions from 1950 to 1985. It met on an annual basis from 1950 to 1967; there was an unexplained four-year gap in meetings between 1968 and 1972; and then annual meetings resumed again until 1982, when another unexplained gap in meetings occurred between 1982 and 1985.

168 Although the management committee was established by, and answerable to, the governing board there is no evidence of formal reporting or contact between the committee and the board during the time that the board failed to meet. It may be that Fr McCann, the chair of the management committee, kept Bishop Philbin informed about matters in Rubane. However, **we consider the lack of formal meetings, and therefore the lack of formal governance of Rubane, in the periods outlined above when Rubane was experiencing significant difficulties and challenges amounted to a systemic failing by the Diocese to ensure the institution provided proper care.**

Daily life for boys in Rubane

169 Before we consider the evidence the Inquiry received about physical abuse, sexual abuse, emotional abuse, neglect and unacceptable practices in Rubane, we will first look at what the daily routine was like for boys in Rubane and positive aspect of the facilities available to the boys and the care they received.

163 RUB 11156
164 RUB 5242.

170 As indicated previously, Rubane House was a large Victorian mansion, close to Kircubbin and approximately 22 miles from Belfast. It had 250 acres of land, was surrounded by woodland and was situated in the middle of the Ards Peninsula. It was in sharp contrast to the city centre environment that many of the boys had come from and its location meant that most boys were a significant distance from their own homes. This made it difficult for family members to visit, particularly when they had to use public transport which necessitated a long walk in both directions from the bus stop to the home.

171 The home was open for a period of about thirty-five years, and just as the physical environment improved with the opening of the chalets in 1968/69 the range of facilities available improved significantly during the life of the home. At the start, the community was confined to the main house and the farm, restricting the range of activities possible, but over time farm buildings and coach houses were used for leisure activities such as table tennis, billiards and showing of films. There were also garden areas and surrounding woodland available to the boys, a general play area with swings and a pet area with animals.[165] In due course, grass and all - weather playing fields, basketball and tennis courts, a play hall, sports hall and a swimming pool were added, which enabled the boys to engage in a wider range of sporting activities.

172 In the early years there were short recreation periods in the yard after lunch and tea, supervised access to television and some occasional screening of films. Boys were allowed to walk to Kircubbin and to a local beach, but they were supervised by a brother on such walks. A number recalled these walks warmly, for example HIA 110 who said:

> "[BR 13] used to take us out for a walk and then we would sit on a wall and he would give us biscuits. We always called this wall biscuit corner."[166]

173 A number of witnesses recognised that they had access to a wider range of activities than they would have had if they had remained at home, for example HIA 36, who was resident in Rubane from August 1968 until May 1972, commented:

> "It wasn't all bad, there were a lot of good times. I don't know anyone who had a swimming pool in their house and two tennis courts and

165 RUB 15.
166 RUB 589.

> a football pitch and a snooker table. We used to go swimming to Newtownards every Saturday and to pictures nearly every other week. As the years went on it got easier and you got to more places."[167]

174 BR 2 described how sporting and other extra-curricular activities were used to develop the boys:

> "From sports, to fishing, hill walking, historical trips, camping, athletics, gardening, pets, disco and music we did try and facilitate opportunities to mix with different sections of the community and gain a sense of self-worth, discipline and responsibility through their extra - curricular activities."[168]

Witnesses confirmed this approach and spoke of taking part in inter-school and inter-community sporting competitions and in bands, choirs and Irish dancing with children from the locality.

175 The daily routine also changed over the years. In the earlier years the approach adopted by the brothers appears to have been more controlling and institutional; witnesses who were in Rubane in the 1950s and early 1960s described a regime structured around religious observance, schooling and completion of daily chores with more extensive cleaning at the weekend. School was the main focus of the day. In his book "Irish De La Salle Brothers in Christian Education" John Towey described how the education provided in Rubane was utilitarian and cultural in content rather than academic: woodwork, art and design, technical drawing, geography, history and maths.[169]

176 We noted that although school was the focus of week days, a number of witnesses complained about the poor standard of education they received in Rubane and how this has affected them throughout their lives. Evaluation of the quality of education provided in Rubane is not within the remit of this Inquiry but the support provided to the boys to engage and progress with learning is relevant. Some witnesses suggested that the brothers did not feel the boys were worth investing time in and that there was no support for homework or any encouragement to take exams.[170]

167 RUB 480.
168 RUB 1056.
169 RUB 60.
170 RUB 420,602,641.

177 HIA 256 described being sent to work in the gardens:

> "Instead of going to school I was sent to work as a gardener with a caretaker....I had learning difficulties, and it seemed I was better out doing this kind of work rather than going to school."[171]

Witnesses also told of being taken out of school to help on the farm[172] and DL 11 confirmed in his statement to the Inquiry that he put a stop to boys from his chalet being used in this way.[173]

178 The Order pointed out that many of the boys admitted to Rubane had poor school attendance records and a history of low achievement at primary education level and that the disruptive behaviour of some boys adversely affected the learning experience of other boys. They also indicated that the absence of the natural separation between school and home life may well have been difficult for the boys to see or understand, with consequential impacts on their educational enjoyment and success. While the Order accepted that physical conditions within the home created a poor environment for individual home learning they pointed to the evidence of DL 40 that BR 6 provided additional voluntary classes in the evening and that of HIA 225 and DL 445 who appreciated how their musical talents were encouraged. We noted that there were improvements over time with the appointment of more lay teachers in the 1970s and that in later years some boys were encouraged to attend school in Portaferry and obtain O-Level qualifications.

179 The routine became more relaxed over the years and BR 2 described a daily routine after the chalets opened in 1968/69 which, while still regimented and built around the school day, allowed two hours between 4pm and 6pm and one hour between 7pm and 8pm for extracurricular activities and did not include time for chores apart from the boys tidying their beds and clothes. He also indicated that there was a more relaxed approach at weekends and school holidays.[174] It was also clear from the accounts of witnesses that over time boys were given greater freedom: for example, they described being allowed to walk to Kircubbin unsupervised, to attend local discos and there were references to older boys being able to meet with girlfriends. One of the older boys, HIA 381, who was placed in Rubane in 1982 aged fifteen and stayed there for two years told the Inquiry:

171 RUB 671.
172 RUB 808.
173 RUB 5943.
174 RUB 1052.

> "I have no complaints about my time in Rubane House. I loved it there. I had a room of my own in chalet one and I was given pocket money and a clothing allowance every month."[175]

180 Witnesses described individual interests being encouraged, for example in growing vegetables and flowers, music,[176] bird watching[177] and keeping pets.[178] A number of witnesses spoke warmly of holidays they had in Glenariff, which was near the sea at the foot of the Antrim glens and the more relaxed regime they were allowed to enjoy there.

181 Many witnesses talked about the value of friendships they forged at Rubane, how they looked out for each other and how the companionship and support of other boys sustained them. It was clear from the accounts of some witnesses that friendships forged in Rubane remain strong today. It was also the case that some witnesses maintained contact over the years with De La Salle brothers and lay staff who worked in Rubane when they were resident there. They told us they were grateful for the care and attention they received from these staff and for the facilities, particularly the sporting facilities that were available to them in the home.

182 We will now consider the evidence the Inquiry received about physical abuse, sexual abuse, emotional abuse, neglect and unacceptable practices in Rubane.

Physical abuse

183 Fifty of the 60 former residents who gave evidence to the Inquiry about Rubane alleged they suffered physical abuse by brothers and lay staff and observed other boys being subject to such abuse.

184 These witnesses clearly distinguished between the administration of corporal punishment in a controlled manner, which they accepted as a reasonable response to misbehaviour, physical punishment which was excessive and aggressive, and violent behaviour which was at times random and unprompted. Witnesses who were resident in Rubane across the four decades of its operation described staff losing control and severely beating boys, excessive caning and strapping which was not limited to hands and behinds, and some staff using their fists and feet to hit boys. They described a culture of physical force being used to assert and maintain

175 RUB 722.
176 DL 445.
177 HIA 170.
178 HIA 41.

authority and control and an atmosphere where the risk of physical violence was constantly present and often realised.

185 Corporal punishment was permissible within the Children and Young Persons (Voluntary Homes) Regulations 1952 and as updated in 1975, with the important proviso that:

> "11(1) The person in charge of a home shall ensure that generally order is maintained by his personal influence and understanding and that of his staff, and resort to corporal punishment shall be avoided as far as possible"

The Regulations set down that minor acts of misbehaviour should be dealt with through forfeiture of rewards or privileges or

> "a light tap of the hand may occasionally be applied to the hand of a child with the object of indicating urgent disapproval rather than that of inflicting pain."[179]

The Regulations also set clear guidelines for how corporal punishment should be administered if it were considered necessary, including the type of punishment that should be administered, the extent of it given the age and state of health of the child and who should administer it.

186 Chapter VIII of the Order's rules also addressed the use of corporal punishment:

> "The Brothers shall be careful never to touch or strike any of their scholars and never to repulse or treat them rudely; all such means of correction should never be used by the Brothers, as being very unbecoming and opposed to charity and Christian meekness."[180]

The rules also specified that if Brothers had to punish boys they should be extremely careful to do so with great moderation and self possession and should:

> "never undertake to punish in hastiness, or when they feel excited."[181]

187 It is clear from the evidence we heard that the restrictions set out in the Voluntary Homes Regulations were not consistently adhered to. The Order accepted in its evidence to the Inquiry that its own Rules about the administration of punishment were not always observed and that on occasions the boundary between corporal punishment and physical

179 HIA 290.
180 RUB 1557.
181 RUB 1556/7.

abuse was definitely crossed.[182] The Order suggested this may have been because there was a blurring by the brothers, many of whom worked in the school in Rubane as well as the home, of the distinctions between how corporal punishment could be administered in school, i.e. with use of a strap, in front of other pupils, and with no requirement to record it and how it should have been applied in the home.[183] If this blurring occurred, it would indicate a failing in the management of staff and in the guidance and oversight provided to them to ensure they understood and met statutory regulations. We consider that the Order's response and explanation appear to ignore or excuse each brother's individual responsibility to meet the Order's rules about the chastisement of children.

188 Witnesses who were admitted to Rubane in the 1950s described a harsh regime of strict discipline, excessive physical punishment for misdemeanours and random unprompted physical violence from brothers. There was consistent evidence, which we accept, that boys were put over desks and beaten on the bare backside with canes and with straps, were hit in front of other boys and were caned until they bled.

189 BR 12, who was the first Br Director of Rubane, was remembered for his use of excessive force: HIA 97 describes BR 12 as a vicious man who would lash out and kick and thump for no reason and HIA 261 recalled BR 12 hitting him on the head and bouncing him off a wall.[184]

190 BR 12 ceased being Brother Director in September 1956 but he continued to work in Rubane until his death in December 1972. Therefore his approach to discipline spanned sixteen years so that, for example, while HIA 19 who was in Rubane from 1966 to 1970 recalled being caned by BR 6 and BR 3 for minor misdemeanours he remembered BR 12 hitting him with a stick on his backside.[185]

191 BR 17 took over as Brother Director in September 1956 and he featured significantly in the accounts we heard of physical chastisement. To some extent this may be explained because he was the officer in charge and in accordance with the Voluntary Homes Regulations would have been responsible for the administration of corporal punishment. However, it is clear from the evidence we heard that he did not administer corporal punishment in the controlled and proportionate manner required by the regulations.

182 RUB 9149.
183 RUB 9127.
184 RUB 700.
185 RUB 442.

192 HIA 252 who was admitted to Rubane on 26 November 1954, aged 9 years, because of non-school attendance described BR 17 beating him for crying because he was homesick[186] and beating him with a stick until he bled for running away.[187] HIA 390 described the head brother, who would have been BR 17 for the majority of HIA 390's time at Rubane, regularly strapping boys across the body, head and face.

193 HIA 183 described BR 17 beating him black and blue with his fists: "he flung me over the table; he fisted me" because when BR 17 asked him what he was learning he said he was learning a hymn; he explained the beating only ended when another boy told him to say he was learning Latin.[188]

194 It was clear from the evidence we received that during BR 17's time as Brother Director boys were gathered together to observe punishments and that on occasion boys were beaten on their bare bottoms and bodies in front of other boys. HIA 261 described two boys who had absconded being dressed in swimming trunks and beaten with a stick by BR 17 so forcefully that they "leapt in the air with pain".[189]

195 It was also clear that absconding was a particular trigger for severe chastisement, and that boys were gathered to watch such punishment as a means of deterring them from absconding. In part, the severe response to absconding appears to have been because the brothers felt it was important to maintain confidence in the Order's ability to deal with boys who had been sent to Rubane because they were seen to be in need of firm discipline. It may also have been that the brothers were concerned about how the local community in Kircubbin would perceive and respond to persistent absconding, particularly when boys who absconded engaged in petty crime in the local area. Whatever the motivation, it is clear that in the earlier periods any boy who was returned to Rubane after absconding could expect a harsh response and little if any discussion about why they were running away. BR 2 explained that part of his motivation to stop absconding was the risk of harm boys put themselves in, especially during the Troubles, and he described having to collect boys from potentially dangerous situations. He also told us he talked to boys on the way back to Rubane and asked them why they absconded.

186 RUB 662.
187 RUB 664.
188 RUB 617.
189 RUB 701.

196 HIA 385 recalled a young boy who was caught smoking being stripped to his underpants, bent over a chair and whipped[190] and HIA 252 described being flogged on the bare backside in front of other boys because he was suspected of having stolen cigarettes.[191] In contrast to the measured approach the Voluntary Homes Regulations and the Order's rules set down for the administration of chastisement, HIA 399 described observing BR 17 hitting boys so hard that sweat poured from him and that "he looked like he was enjoying it too much."[192]

197 In addition to the evidence about excessive physical punishment, witnesses told the Inquiry about the unpredictable nature of the physical regime in Rubane and how brothers would administer random slaps. HIA 244 described it as follows:

> "Rubane was just a hell hole; it was a complete nightmare. We were constantly ducking and diving from the Brothers; you never knew when you'd get hit by them."[193]

HIA 247 spoke in particular of how unpredictable BR 17 could be, "smiling and joking one minute and then going into a rage".[194]

198 Witnesses also said that when they received injuries as a result of beatings from brothers or staff they did not receive external medical treatment and often did not receive any assistance from staff:

> "...if we got a bad beating no one would patch us up"[195] HIA 390.

199 Although the regulations stipulated that only the officer in charge or his duly appointed deputy should administer corporal punishment, it was clear from the accounts of witnesses that this was not adhered to. BR 15 who arrived in Rubane in 1956 and BR 14 who arrived in 1957 were particularly remembered for using excessive and at times random physical force against boys.

200 HIA 385 remembered BR 15 as a cruel man who ruled by fear.[196] HIA 183 described BR 15 hitting a boy across the face with a bamboo cane and continuing to hit him across the legs and back with the cane although

190 RUB 733.
191 RUB 665.
192 RUB 868.
193 RUB 652.
194 Day 57 8 October 2014, pp. 38 and 39.
195 RUB 743.
196 RUB 732.

blood was pouring from the boy's face.[197] HIA 252 and HIA 244 described BR 15 hitting boys in the shower with a strap and a bamboo cane.[198]

201 HIA 390 told the Inquiry that BR 15 would return to Rubane from trips to Belfast in a drunken state and would come to the dormitory and randomly physically abuse boys.[199] The Inquiry particularly noted that HIA 36 said the brothers were fair and that when he got "six of the best" it was for breaking rules but he described BR 15 as bad tempered and recalled him hitting boys with a stick.[200]

202 BR 15 was described as having a vicious temper[201] HIA 183, HIA 252 described BR 14 hitting him around his face with a strap and kicking him in the side with the toe of his shoe "like someone would kick a football."[202]

203 BR 6 was the Brother Director in Rubane from August 1962 to July 1971. He is remembered warmly by his fellow brothers and some residents talked of his kindness - "a smashing fellow".[203] However, it is clear from the evidence we heard that under his leadership harsh physical discipline continued to be a feature of life in Rubane. HIA 110 described BR 6 hitting him with a stick, HIA 16 described him hitting boys for not doing their cleaning chores properly and HIA 225 recalled him hitting a boy across the face with a cane because he had pointed out that BR 6 had spelt a word wrongly. HIA 259 commented about BR 6:

> "...although he could be nice to you at times you did not want to get on the wrong side of him as he had a very bad temper and would really tear into you".[204]

204 The public nature of some punishment also continued, HIA 34 described BR 6 slapping boys in the yard. HIA 36 described boys being assembled to watch two brothers DL 368 and DL 536 being stripped and beaten for running away. HIA 26 who was in Rubane from 1964 to 1970 referred to excessive use of the cane:

> "The cane would leave lumps and welts on your legs and on occasion they would beat you until your bare legs would bleed."[205]

197 RUB 619.
198 RUB 665.
199 RUB 740.
200 RUB 478.
201 RUB 619.
202 RUB 665
203 DL 244 - RUB 1486-1489.
204 RUB 679.
205 RUB 456.

205 BR 2, who worked with BR 6 accepted that he caned boys in front of other boys but insisted that such caning would have been on the boys' hands not their behinds.

206 A number of witnesses described how some brothers asserted their authority when boys arrived in Rubane and warned them about what they could expect if they did not behave. HIA 21 gave an example of this behaviour: he described how on his first night in Rubane BR 3 hit him across the face for no reason and with no warning and told him "You are not in Nazareth Lodge now".'[206] HIA 21 told us that was the only time BR 3 "struck-out" at him.

207 HIA 225 was the only witness who was in Rubane at this time who told us he reported how he was chastised to his social worker; he told her that he had been badly caned by BR 4. He said he was not sure if his social worker did anything about it but that BR 4 did not hit him again. The HSCB provided relevant social work papers which confirmed that HIA 225 told his social worker that he had been "strapped and then hit across his left ear by BR 4, such as to knock him off his chair"[207] and that she advised him to ignore the incident unless BR 4 continued to punish him unjustly whereupon he should discuss the situation with BR 6. The social worker recorded that this plan seemed to satisfy HIA 225.

208 The HSCB accepted in its written submission to the Inquiry that BR 4's behaviour as described by HIA 225 amounted to serious physical abuse and that there is no evidence that she reported the incident to her line manager. They suggested that this could be because the possibility of institutional abuse did not register with her. We accept this may be the case and while we would expect a social worker to refer such a matter to his/her manager we accept that she did not record both HIA 225's complaint and her follow up action to ensure that HIA 225 was not subject to further abuse.

209 We also note that BR 2 recorded in his diary how BR 4 dealt with boys who had stolen altar wine and spirits and got drunk as "BR 4 goes to town on them"[208] and we conclude from this that BR 4's behaviour with HIA 225 was not a one-off incident. Although the social worker could not have been aware of that, it was a significant failing that she did not refer

206 RUB 879.
207 RUB 9245.
208 RUB 2630.

the matter to her manager, as such a referral might have resulted in an investigation into BR 4's behaviour or, at the very least, questions about the incident that might have made him control his behaviour better.

210 A number of witnesses recalled brothers enforcing a white boundary line in the play ground (e.g. HIA 152) denoting the area within which they were expected to remain during recreation time. The Order explained that this line was used for a period in Rubane and was a means of enabling supervision of the boys and preventing them from wandering in the outer fields and woods where there was a risk they would engage in sexual activity and bullying behaviour. We accept that a boundary line may have been necessary since the grounds surrounding Rubane were extensive and that the use of a boundary line would enable one brother to supervise a large number of children at recreation time. However, we accept from the evidence of witnesses (e.g. HIA 244) that some brothers and in particular BR 28 were overzealous in their enforcement of the boundary.

211 Some witnesses who were in Rubane in the mid-1960s onwards recalled other forms of punishment, such as pocket money being withheld,[209] and remembered only seeing other boys being punished if they happened to be in the vicinity as opposed to being convened to watch punishments. The introduction of chalets improved the physical environment for the boys and heralded the introduction of more lay and female staff. However, from the evidence we received we accept that physical punishment continued to be the primary means some brothers and lay staff used for asserting their authority and maintaining their control over the boys.

212 To illustrate this, we refer to some of the behaviour of staff that BR 2 had to deal with during two of his periods as Brother Director in Rubane, July 1971 to September 1973 and June 1980 to December 1982, and that BR 1 had to deal with during his period as Brother Director from September 1973 to September 1977.

213 BR 2 confirmed in his evidence to the Inquiry that as the Brother Director he received complaints from boys about staff being physically abusive. The extracts from his diaries, which he helpfully provided to the Inquiry, illustrated well the type of behaviour the boys were complaining about.

214 Before his appointment as Brother Director, while he was working as a teacher and a part-time member of care staff in Rubane, BR 2 was already

209 HIA 64 and HIA 97 (Day 56, p.13).

concerned about the behaviour of a house parent, DL 421. He recorded in his diary on 7 December 1970:

> "Screams from upstairs – went upstairs [DL 421] and [HIA 56] in the toilets [HIA 56] cowering [DL 421] over him 'this can't go on' ...talked to [DL 421]."[210]

215 On 20 Dec 1970 BR 2 recorded in his diary that some boys had complained to the Chaplain, DL 140, about DL 421's behaviour and that DL 140 intended confronting DL 421 but BR 6 intervened and he and DL 140 talked to DL421 together.

216 Following his appointment as Brother Director, BR 2 recorded continued concerns about the behaviour of DL 421. For example, he recorded on 30 January 1973 a boy coming to see him because he was afraid of going to his chalet because he had lost his pullover and would get "the black belt" from DL 421. On another occasion he recorded five boys complaining about DL 421, three of whom were subsequently moved from his chalet because of his aggressive behaviour towards them. He eventually asked DL 421 and his wife to resign on the basis that they had reached retirement age. BR 2 confirmed in his oral evidence that he did not tell the management committee or the governing board about asking DL 421 and his wife to resign or the reasons for their departure.

217 Subsequent to DL 421's resignation the home was searched by security forces and BR 2 was told on a confidential basis that this search was linked to a member of lay staff hiding an escaped IRA prisoner in the home. BR 2 concluded that given DL 421's republican views he was the most likely member of staff to have hidden the escaped prisoner. BR 2 told us that he did not inform the MoHA about the building being searched by the security forces. Dr Harrison on behalf of the Department was critical of this lack of openness but the Order pointed out that BR 2 would have understood that security matters should be kept confidential and would have reasonably expected the police or the security forces to have informed civil servants about the search of Rubane. It is unclear what, if any, information about the search was provided by the security forces to the Department or the HSCB. **We consider it a systemic failing that the Order did not inform the Department or the Health and Social Services Boards about the search of Rubane and the reasons for it and therefore did not work with them to identify and manage any continuing risk to the welfare and safety of the boys in Rubane at that time.**

210 RUB 6268.

218 In 1972 BR 2 had to deal with two brothers whose aggressive behaviour towards boys caused him concern. He recorded their behaviour in his diary, for example:

- "5 February 1972 – BR 29 hits J McNeilly in the dining hall"[211]
- "17 April 1972 – BR 29 clobbers a few boys at the line-up."[212]
- "22 April 1972 – BR 29 at war with little DL 243 (came crying to me, BR 29 beats him again for reporting to me - stupid man".[213]
- "9 June 1972 – BR 29 & BR 20 beat up DL 65 in boys changing room."[214]

219 BR 2 told us that he discussed his concerns about BR 29 with the Provincial and as a result BR 29 was asked to leave Rubane and was not permitted to take his final vows.[215] BR 2 said he was also instrumental in preventing BR 20, who was involved in "beating up [DL 65]", and another brother DL 525 from taking their final vows; he reported to the Provincial that they had poor relationships with the boys and that he did not feel they were able to manage the role properly.[216] The Order pointed out that although BR 2 correctly brought these entries to the attention of the Panel the number of entries in his diary about the misconduct of brothers is relatively few.

220 BR 29 gave evidence to the Inquiry and explained that he entered the Order at age fourteen and although he expected to become a teacher the path that was directed for him was a career in social care. He arrived in Rubane in September 1971 when he was aged nineteen years and stayed less than a year, leaving in July 1972 when his vows were not renewed. BR 29 told us that his understanding at the time was that he was leaving the Order because he did not have the vocation to continue in the religious life or the prayer life to sustain such a vocation. He also informed us as part of the Warning Letter process that BR 20 took his final vows and was still a brother in 1977. We took from this that while BR 2 may have played a part in delaying BR 20 from taking his final vows in 1972 BR 20 was subsequently allowed to take them.

211 RUB 6370.
212 RUB 6411.
213 RUB 6413.
214 RUB 6441.
215 RUB 1049.
216 RUB 1050.

221 BR 29 told us that as a nineteen-year-old man with no experience, and no training or preparation for the work, he was thrown in at the deep end and expected to deal with boys, some of whom were only a few years younger than him, and whose behaviour could be very challenging. He said he had a vague memory of a boy suddenly attacking BR 20 and him in a changing room and of them having to restrain him but could not recall the other incidents involving his interactions with boys recorded by BR 2. He told us that he received no job description, no supervision and limited guidance about doing his job. While not excusing BR 29's behaviour towards boys we accept that he was ill-equipped for his work with the boys and unsupported in carrying it out. We consider that he was not alone in this regard and we will return to the matter of support and supervision of staff later in this chapter.

222 BR 2 issued a verbal warning on two occasions to another member of staff, DL 279. The first warning was for physically assaulting a boy while on duty under the influence of alcohol on 25 March 1975. The second warning related to an incident on 29 January 1976 when DL 279 was again on duty under the influence of alcohol and assaulted another boy and left him with a swollen jaw. BR 2 recorded in his diary that on 21 January 1976 he had a brief chat with DL 279's wife, DL 89, about her husband's aggressiveness and drinking habits but he confirmed in his oral evidence to the Inquiry that he did not refer his concerns about DL 279's behaviour to the provincial or the management committee. It was not until 30 November 1976 that DL 279 was asked to resign and it appears from BR 2's diary that the reason he was asked for his resignation was because he was having an extra-marital relationship with a woman from the locality and was rumoured to be father of her recently born child.

223 In his diary entry of 11 November 1976[217] BR 2 recorded concern about acting in relation to this matter without firm information "Nothing definite - only rumours" and adds at the end of that entry "[DL 279] reported under influence" but gives no indication of his thoughts about that report or any action he took in relation to it. In his oral evidence BR 2 indicated that it was a combination of concerns about DL 279 that prompted him to ask for his resignation, but we noted that his diary entry about his discussion with DL 279 focused on the extra-marital relationship. This left us with the impression that BR 2 was prepared to act more quickly in response to moral failings and perhaps to avoid scandal in the neighbourhood than

217 RUB 7108.

he was to deal with a member of staff who on at least two occasions had assaulted boys while working under the influence of alcohol. BR 2 accepted in his oral evidence to the Inquiry that he should have taken action earlier about DL 279's behaviour but explained that a misplaced sense of sympathy for DL 89 and her children stopped him from doing so.

224 In contrast to BR 2's handling of DL 421 he did seek the advice about handling the situation with DL 279 from Fr McCann, chair of the management committee, and Ms Forrest of the MoHA, who BR 2 recorded as advising a sympathetic approach.[218]

225 BR 2 also had to speak on two occasions to BR 18 in June 1973 and April 1974 about his physical behaviour towards the boys. A number of witnesses to the Inquiry described being hit by BR 18.[219] HIA 31 described BR 18 "knuckling" him so severely on the head that his face went into his food; he contrasted BR 18 hitting him "for nothing" with BR 3 hitting him for doing something wrong.

226 HIA 18 described being severely beaten by BR 18 in the canteen and his account is supported by HIA 259 and DL 85.[220] HIA 259 recounted that DL 11 who was HIA 18's house-parent remonstrated with BR 18 about this incident. In his statement to the Inquiry DL 11 confirmed he did challenge BR 18 about the incident:

> "I said that if he ever hit one of my boys again he would have me to answer to."

He also recalled reporting the matter to BR 1 or BR 2 and saying:

> "that if anything like this happened again I would inform the authorities and if HIA 18 wanted to take the matter further I would back him one hundred percent."

He said he subsequently checked with HIA 18 but he did not want to take the matter further.[221]

227 In addition to evidence from witnesses who were resident in Rubane about BR 18 we noted that a former member of lay staff DL 81 told the police that BR 18 was notorious for punching boys[222] and said in his evidence to the Inquiry that BR 18 would even have given him a thump. DL 149,

218 RUB 7113.
219 HIA 34, HIA170, HIA362 and HIA 149.
220 RUB 60414.
221 RUB 5944.
222 RUB 67797.

who was a teacher of physical education in Rubane, told the Inquiry he remembered that BR 18 had a reputation as:

> "a rough kind of a guy that you didn't mess with sort of thing. That's what the boys would say. You'd jump out of his road sort of thing, you know."[223]

228 When responding in his oral evidence to questions about BR 18's physical punishment of boys BR 2 recalled:

> "…when boys came to me and says [sic], I was hit by BR 18, I would have taken it for granted that he gave them a clout, or a wallop, or a slap or something of that nature, and it was dealt with internally."[224]

229 BR 2 went on to suggest that BR 18's behaviour and his response to it needed to be understood in the context of the time:

> "…but at the time, the times we were in, 60's and 70's, many teachers not so much care workers I guess – but for teachers it would be common practice almost that they would come along and give a warm ear to someone or slapped them – gave them a punch or whatever".[225]

230 It appears that when BR 2 arranged for BR 18 to leave Rubane in 1981 it was not in response to concerns about BR 18's physical aggression towards the boys but was because BR 18 had developed a dependency on alcohol.[226]

231 It is clear that in the 1970s Rubane was increasingly seen by the Health and Social Services Boards as a place to send boys who were in need of firm discipline. BR 2 said in his written statement that by 1974:

> "…the Welfare Authorities valued the closer supervision provided at Rubane as being vital to the upbringing of these boys who were 'out of control' in other institutional settings."[227]

232 We also heard about boys being sent to Rubane from Termonbacca and Nazareth Lodge because the nuns could not control their behaviour and it would appear from the evidence we heard that the brothers took a particularly physical approach to asserting their authority with these boys. For example HIA 94 was transferred from Termonbacca in 1972 because the nuns could not handle his behaviour. He described physical abuse by brothers, including being caned on his bare behind, and the Order has confirmed that records

223 Day 73, 26 November 2014, p. 66.
224 Day 74, 27 November 2014, p. 43.
225 Day 74, 27 November 2014, p. 45.
226 RUB 5763-5764.
227 RUB 1043.

show he was punished for his behaviour and for absconding. HIA 25 and his twin brother HIA 31 were admitted to Rubane in 1974 although they were only aged 7 years because the nuns in Nazareth Lodge could not deal with their behaviour. HIA 25 described how he and his brother HIA 31 ran away soon after arriving in Rubane and when they were brought back they were beaten by a brother. He stated:

> "Now we were only 7 years of age and this was a grown man with a big stick hitting us as hard as he could to try to teach us a lesson not to run away. It wasn't a lesson not to run away. It was a lesson of fear, you know"[228]

As previously stated, the statutory regulations regarding corporal punishment forbade children under eight being punished in this way.

233 In his written statement to the Inquiry BR 2 accepted "there will have been times when punishment was not carried out strictly in accordance with the regulations"[229] and that he himself had "momentary loss of self control'. He referred the Inquiry to his diary entry for the 10 January 1973 where he recorded, "hit [DL 315] across the face for being giddy."[230] This record in BR 2's diary of his spontaneous informal chastisement of a boy is unusual; other entries about physical punishment record his administration of corporal punishment.

234 HIA 222 and his brother DL 385 were admitted to Rubane because following the death of their father they got beyond their mother's control and began to miss school and get into trouble. HIA 222 told us that on his first day in Rubane the head brother, who at that time would have been BR 2, slapped him because he and his brother were "kicking off" as they did not want to be in the home. It was also recorded in the Ledger five days later, on 8 October 1974, that when HIA 222 and DL 385's mother and a social worker were leaving Rubane at the end of a visit the boys had to be restrained because they wanted to leave with them. It was specifically recorded "A few clouts to [DL 385]."[231] BR2 also recorded the incident in his diary and commented "[DL 385] very stubborn – took a lot out of me."

235 This attitude to the physical chastisement of boys contrasts with the oral evidence given to the Inquiry by Mr Bunting, who in reference to BR 2's

228 Day 66, p. 105, Lines 18-22.
229 Para 130 RUB 1084..
230 RUB 1084.
231 RUB 3299.

evidence about brothers' overly physical treatment of boys stated that if the type of incidents which caused BR 2 concern had happened in statutory homes they would have been formally investigated and any behaviour amounting to physical assault would have been referred to the police.[232] While accepting that corporal punishment was still commonplace in schools in the 1970s, in relation to its use in statutory children's homes at that time Mr Bunting stated:

> "it was not our practice in statutory homes for any form of physical chastisement."[233]

236 We appreciated BR 2's frankness about these matters and noted that he regularly recorded in his diary when he chastised boys, how many slaps he gave and for what reason. He explained in his oral evidence that he would have punished boys together if they had offended together, but would have punished boys alone if they offended alone, and that if he saw boys fighting he would intervene to stop the fight and would have slapped both boys. HIA 191 provided an example of this approach when he described BR 2 giving him "six on each hand" for fighting with another boy.

237 We also noted that BR 2 recorded giving other non-physical punishments such as not allowing a boy to go to the swimming pool[234] and giving a boy 50 lines for being down the field after supper.[235]

BR 77

238 We will now consider the case of BR 77 who is the only brother who worked in Rubane to be convicted for physical abuse of the boys in his care. At the time of the behaviour that led to BR 77's convictions BR 1 was the Brother Director of Rubane, having been appointed to that post in October 1977.

239 BR 77 arrived in Rubane in September 1976, to take up his first teaching post. He explained to us that he lived in St Patrick's while completing his training as a teacher and from what he observed of the work there he felt he would not be suited to working in Rubane. He told us he tried to convince Provincial, Br Columba Gallagher, of this but was unsuccessful and was sent to work in Rubane.

232 Day 76, 9 December 2014, Page 142.
233 Day 76, 9 December 2014, Page 145.
234 RUB 6370.
235 RUB 6284.

240 He told us that he got no advice about how to deal with the behaviour of the boys beyond being advised to read their files and that the only guidance he got was about the level of academic attainment the boys should be expected to achieve.

241 The first incident that led to his conviction occurred in November 1979 when DL 48 was hit on the eye by BR 77 for "messing around" on the football pitch. The cut required stitching. When DL 48 was interviewed by the police in 1980 about this incident he told them that he did not tell his social worker about it because he was scared of BR 77 but that he did tell BR 1 but thought that he did nothing about it.

242 BR 1 told the police on 1 October 1980 that he told the management Committee about this incident,[236] but this is at odds with the account that Fr McCann, who was the chair of the management committee, gave to the police[237] and to the Hughes Inquiry.[238]

243 Fr McCann said the matter came to his attention because Pauline Richardson, a social worker with the Catholic Welfare Office who was liaising with staff in Rubane in order to help develop their care practices, heard about the incident from boys in Rubane and reported it to her Director, Fr John O Connor, who in turn reported it to Fr McCann. In a statement to police[239] Fr McCann recounted going to meet with BR 1 to discuss the matter and telling him to give BR 77 a warning about his behaviour.

244 It does not appear that Fr McCann asked for confirmation that the warning had been given and in his evidence to the Inquiry, BR 77 stated that he had no memory of receiving such a warning. Neither BR 1 nor Fr McCann referred the matter to the police or to DL 48's social worker and Fr McCann accepted in his evidence to the Hughes Inquiry that his reaction was not sufficient.

245 The second incident occurred around March 1980,[240] when DL 52 was attacked by BR 77 during a basket ball game in the sports hall. In his statement to police DL 52 explained that he had told his friend DL 60 he would hit him if he dropped the ball and that when DL 60 did drop the ball he gave him a playful tap on the head. DL 52 described to the police how

236 RUB 60139.
237 RUB 60049.
238 RUB 40016.
239 RUB 60049.
240 RUB 60106.

BR 77 responded to this:

> "BR 77 came over to me and punched me on the jaw. I tried to cover myself up and he kept on punching me with both fists until I fell and hit my head on the wall. When I was on the ground he kept on hitting me and cut my upper lip. He also kicked me once when I was on the ground. After he saw that I was bleeding from the lip he tried to make up to me by saying it was an accident. He attended to the cut on my lip himself and I did not have any medical treatment."

246 DL 52 reported what happened to BR 1 and BR 3, who was the principal of the school. In his evidence to the Inquiry, BR 77 said he told BR 3 himself about the incident, explained that he intervened to stop DL 52 hitting DL 60 but knew that he had overstepped the mark. He also told the Inquiry that three weeks after the incident he apologised to the boys in DL 52's class who had observed the beating. In his statement to the police[241] DL 60 stated that he knew DL 52 was only carrying on and confirmed that BR 77 apologised to the class for his behaviour.

247 When answering questions at the Inquiry hearing about this incident BR 77 stated that his conversation with BR 3 did not include discussion of how he might contain and manage himself better in future to avoid the reoccurrence of such behaviour. Despite Fr McCann's intervention in relation to the first incident and the warning he said BR 77 was to receive, BR 1 did not alert Fr McCann to the second incident and did not report it to DL 52's social worker or the police. Therefore, although BR 77 serious assaulted two boys within a five month period he was not disciplined or removed from his post.

248 In February 1980 DL 517, a social worker employed by the Eastern Health and Social Services Board, and DL 522 of the Down and Connor Catholic Family Welfare Society started a Leavers Group in Rubane to help boys to prepare for leaving care. At a meeting of this group on 6 March 1980, the boys made clear that they did not want BR 77 to join them on a planned weekend away because he was generally vicious and aggressive, had split a boy's lip, hit boys with mountaineering rope on previous camping trips, and, that if he did not like the way boys behaved on the weekend away he would "get them" when they returned to Rubane.

241 RUB 60196.

249 On 10 March 1980 DL 517 visited a boy in Rubane DL 33, who she was the social worker for, and he told her BR 77 had hit him in the laundry for smoking. He asked her not to tell BR 1 about him being hit as it would make things worse. DL 33's father who has accompanied DL 517 on the visit suggested that his son might be exaggerating the severity of the beating.

250 At the next meeting of the leavers group on 13 March 1980 the boys expressed the same concerns about BR 77 and as a result DL 522 met with BR 1 and shared the concerns expressed by the boys and asked that BR 77 should not be chosen to accompany the group on the weekend away. BR 1 gave DL 522 a non-committal response to this request. There is no evidence to suggest that at this point either DL 517 or DL 522 escalated their concerns about BR 77's behaviour to their managers.

251 However, on 27 March 1980, DL 517 and DL 522 decided to discuss the boys' concerns further with BR 1 and DL 517 also raised DL 33's report to her of being hit by BR 77 in the laundry. BR 1 assured the social workers that he knew about the incident of the boy being given a split lip by BR 77 and had dealt with it and that as far as he knew there had been no more incidents since then.[242] On 14 April 1980 DL 517 met with DL 33 who told her he had been hit again by BR 77. DL 517 reported this to BR 6 in BR 1's absence and she subsequently submitted a report to her senior managers about the allegations the boys in the group and DL 33 had made about BR 77.[243] DL 524, District Social Services Officer, referred the report to Mr Gilliland, Director of Social Services, with a memo dated 18 April 1980[244] advising that the matters should be raised with the police, the DHSS and the management committee of Rubane.

252 The police had already been alerted to allegations of sexual misconduct by BR 1, which we will consider later in this chapter. The combination of concerns led the police to decide to interview boys who were in Rubane between 1977 and 1980, a total of 129 boys of whom 124 were traced and interviewed. During these interviews eighteen boys made allegations of physical assault against BR 77 and ten of them described him beating them around the head and face and striking them on the mouth and eye with a closed fist.

242 P. 56, Day 77.
243 RUB 1691-1694.
244 RUB 1690.

253 Fr McCann was informed by police about these allegations and on the same day asked BR 77 to absent himself from Rubane and not be in communication with it in any way. We noted that despite knowing about the incident with DL 52 Fr McCann explained to the Hughes Inquiry that out of delicacy he asked BR 77 to absent himself from Rubane rather than telling him he was suspended. Despite the serious allegations made against BR 77 the Order moved him to teach in a local school.[245]

254 In the report of the 1981 inspection of the home by the Social Work Advisory Group there is a passing reference to BR 1, and a lay member of staff DL 509 being under suspension from duty at the time of the inspection but there is no reference to BR 77's suspension or the circumstances surrounding it. This suggests that this information may not have been shared with the inspection team.

255 The Police decided to prefer charges in relation to four of the allegations against BR 77 where there was evidence of corroboration. Three assaults of occasioning actual bodily harm against DL 48 in October 1979, DL 52 in March 1980 and DL 53 in early 1980 were proceeded with. BR 77 appeared at Ards Court on 11 May 1981, pleaded guilty and was given a conditional discharge on each of the counts.

256 Five witnesses to the Inquiry described physical abuse by BR 77. HIA 170 recalled BR 77 "busting the nose" of a boy called Shields. HIA 259 described him as terrifying and intimidating and said he beat boys excessively and got a buzz from it. HIA 218 described BR 77 hitting him and his twin brother with a climbing rope, and HIA 18 described BR 77 beating him with a golf club and said BR 6 observed that beating and did not intervene.

257 HIA 41 said BR 77 beat him in a store room in Rubane and that he lifted boys by the hair, tried to make them cry and left DL 53 in a pool of blood. A witness put forward to the Inquiry by the Order, DL 40, said in a police interview that BR 77 hit him with his fists for not paying attention in class and that another boy, DL 46, told him about a beating he got from BR 77.

258 In his evidence to the Inquiry BR 77 accepted that he behaved wrongly on the occasions for which he was convicted and that he did use a rubber tube and a safety line rope used for climbing to hit boys, but he denied the other allegations against him.

245 RUB 40021.

Conditions after the return of BR 2 as Brother Director

259 As a result of allegations of a sexual nature against BR 1, Bishop Philbin suspended him and the Order sent BR 2 back to Rubane to take up the post of Brother Director again. At BR 2's insistence he was given the support of a deputy BR 7. BR 7 told the Inquiry that his general impression of Rubane when he arrived was that there was an overemphasis on sanctions and punishment, and that he suggested a more positive approach of rewarding good behaviour. He also introduced reviews of boys, log books, personal records for each boy and an independent living scheme. This period marked a time when the boys were given more freedom, for example to walk into Kircubbin or go to discos, and we heard evidence from witnesses about such privileges being removed as punishments.

260 BR 7 said there was a marked shift towards reducing the use of corporal punishment and reactive informal punishments such as clipping of boys' ears. He also described how arrangements were put in place that only BR 2 and he would administer corporal punishment and that it was not to be administered in the heat of the moment. While we did not accept every allegation about physical abuse by brothers in these later years we concluded from the accounts of witnesses that the restrictions described by BR 7 were not always adhered to and that brothers continued to use their superior physical force to exercise authority over the boys, as did lay staff.

DL 81

261 To illustrate this we will consider the conduct of a lay member of staff, DL 81 who was the member of staff whose reports to external agencies about poor child care and management practices in Rubane led to the EHSSB placing an embargo on placements in Rubane.

262 DL 81 was 20 years old when he commenced work in Rubane and he worked there until he was 25 years of age. He completed a course leading to the Certificate in Residential Care of Children and Young People at Rupert Stanley College and while he was on the course he worked as a house parent in the evenings in Chalet 3 and he and his wife lived in that Chalet. When he completed his training, he and his wife were moved to Chalet 2 where he worked with DL 514, a psychology graduate, under the management of DL 11 and his wife DL 12.

263 A series of incidents took place where DL 81 got into physical confrontations with boys. In Feb 1981[246] a boy (DL 212) threatened DL 81 with a poker and told staff he did so because DL 81 had hit him. On 10 Dec 1981 another boy, DL 413, complained that DL 81 grabbed him by the throat and left marks on him. BR 2 received advice from Pauline Richardson, social worker with the Catholic Family Welfare Office, about how to investigate and report this second incident. During the investigation DL 81 admitted slapping DL 413 across the face and attempting to restrain him, using a technique developed in America which he had heard about but which he had not been trained to use. BR 2 issued a verbal warning to DL 81[247] for "rough handling", arranged for Father O' Connor a member of the management committee to be informed about the incident,[248] and the Newry and Mourne Social Work Department, which was responsible for DL 413.[249]

264 On 25 Jan 1982 a boy, DL 520, pulled a knife on DL 81 who slapped him across the face. This incident was reported to BR 2's deputy BR 7[250] and the next day, 26 January 1982, DL 81 had a confrontation with another boy, DL 415, and BR 2 was involved in managing the aftermath of that incident.

265 It is clear from documentation we have seen that there were tensions in the working relationships DL 81 and DL 514 had with the house parents in Chalet 2, DL 11 and DL 12, and that there were differing views about how the chalet should be run. The contemporaneous written accounts that DL 81 and DL 514 provided to BR 2 about the incidents outlined above show two immature members of staff trying to deal with challenging behaviour from boys in a manner that escalated rather than diffused situations, and DL 81 in particular trying unsuccessfully to use physical force to assert his authority over boys.

266 Two witnesses to the Inquiry, HIA 41 and DL 73, described DL 81 beating them and a witness put forward by the Order DL 40 remembered DL 81 as having a temper.[251] BR 2 accepted to the Inquiry that maybe DL 81 was too aggressive with the boys.

246 RUB 63281.
247 RUB 68222.
248 RUB 68193.
249 RUB 68226.
250 RUB 68242.
251 RUB 1484.

267 DL 81 gave evidence to the Inquiry and denied the allegations made against him. He said he was known as a softie, but that he did get caught up in incidents when he tried to intervene to stop younger boys being bullied by older boys. Subsequently, as part of the Warning Letter process, DL 81 told us that he had slapped HIA 41 but explained that was in response to a crude and unkind remark that HIA 41 made to him and his wife at a time when they were particularly vulnerable. We considered this was an example of the provocative type of behaviour that staff in Rubane would have had to deal with and that it highlighted how important it was for them to be properly supported in their work and the adverse impact when that support was not available.

268 On 27 January 1982 DL 81 met with Fr O'Connor, a member of the management committee, to share his concerns about recent incidents in Rubane and how they had been managed. Father O'Connor wrote to BR 2 and the DHSS to inform them about this meeting and said that he had told DL 81 a review of the running of the home was imminent and that he could take his concerns to the chair of the management committee, Fr McCann.

269 On 4 February 1982 DL 81, accompanied by his colleague DL 514, brought his concerns to Mr Morris, the principal social worker in the EHSSB,[252] and as a result the EHSSB decided on 6 February 1982 to place an embargo on any more admissions to Rubane until the concerns raised by DL 81 and DL 514 could be investigated further.[253] The EHSSB referred the matter to the DHSS and two inspectors from SWAG went to Rubane to meet with DL 81 and DL 514, BR 2 and other relevant staff.[254]

270 One of the claims made by DL 81 was that BR 18 had a drink problem and was frequently on duty in an intoxicated state. The inspectors raised this with BR 2 who confirmed BR 18's dependence on alcohol but was emphatic he was never allowed to go on duty while under the influence of alcohol and that once the problem became apparent he was moved to another De La Salle community. The inspectors accepted this explanation. We are not convinced that boys would not have come in to contact with BR 18 when he was under the influence of alcohol, given the proximity of the living conditions. This is the third allegation that members of staff who were known for their quick temper and physical abuse of boys were also

252 RUB 11960.
253 RUB 5761.
254 RUB 5762/3.

working under the influence of alcohol (BR 15, DL 279 and BR 18). We consider the Order's tolerance of this behaviour was a failure to properly protect the boys, particularly since we are aware that some boys were received into care because of the problems created by one or both of their parents' dependence on alcohol.

271 The inspectors also accepted reassurances from BR 2 that practices in Chalet 2 that DL 81 had complained about, such as the manner in which boys were required to wash their feet each evening, had been stopped.

272 The management committee was informed about the embargo and how it had come about and decided that DL 81 had brought the home into disrepute and should be offered the opportunity to resign.[255] When DL 81 refused to resign he was dismissed on 8 March 1982 by Fr McCann as chair of the management committee and DL 514 had her probation period extended.[256] We considered this an interesting example of how whistle blowing was dealt with; it appears the management committee decided to get rid of the source of the complaints rather than considering whether there was any substance to them. What is more significant in relation to the remit of this Inquiry is that DL 81 was dismissed for bringing the home into disrepute rather than for his unsafe child care practice and physical aggression towards the boys.

273 In light of the SWAG inspectors' acceptance of BR 2's assurances, Mr PJ Armstrong, Deputy Chief Social Work Adviser, wrote to Mr Gilliland, Director of Social Services Eastern Board, on 6 April 1982:

> "I am sure that you will agree that, while there can be room for improvement in the standards of child care in this Home, as in many others both statutory and voluntary, the practices complained of did not represent a serious threat to either the safety or welfare of the boys. ...In my opinion there is now no reason for your Board to maintain an embargo on the admission of boys to Rubane. Social workers who have responsibility for children whom they consider would benefit from the type of treatment and regime that is offered by the Home should recommence referrals."[257]

274 However, as we will consider later in this chapter, further concerns about Rubane were brought to the attention of senior managers in the EHSSB and the embargo remained in place until 5 August 1982.

255 RUB 11070.
256 Ibid
257 RUB 11956.

Excessive physical force by other lay staff

275 Numerous allegations were made to us that lay teaching staff resorted to hitting boys to enforce discipline in the classroom, during games and on occasion when performing other duties, such as acting as a house parent. These allegations range from throwing wooden items at boys in class to slapping and punching boys.

276 For example, a number of witnesses gave consistent evidence that the woodwork, teacher DL 6 was quick to lose his temper, prone to throwing whatever was near to hand, including tools such as chisels and mallets at boys (HIA 19) and hitting them with lumps of wood (HIA 132). A number of witnesses indicated that if a boy was willing to learn DL 6 was a good teacher and was very skilled at woodwork but even they referred to his quick temper. HIA 64 said about DL 6:

> "He was a brilliant teacher but he was very aggressive. If you got something wrong in class, he would call you a fat head and hit you. Then he'd throw the leg of a chair at you and you would have to make a run for it."[258]

It is clear the brothers knew about DL 6's behaviour. For example, HIA 44 told the Inquiry he was moved from DL 6's class because he reported to BR 2 that DL 6 had hit him with a hammer. In its written closing submission to the Inquiry the Order noted the accounts of DL 6's behaviour but pointed out that the boys would wind him up.[259] HIA 170 confirmed this in his evidence to the Inquiry: 'He (DL 6) was definitely a target for being wound up'.[260] The Order acknowledged that it was not acceptable for DL 6 to respond in the way in which he did. We agree and we consider that the Order's willingness to allow him to behave in this way for a number of years was also not acceptable.

277 DL 149 was another member of lay staff about whom the Inquiry received allegations of physical abuse. Rubane was DL 149's first teaching post; he taught Physical Education and Religious Education and lived on-site during the week.

278 DL 149 denied the allegations that witnesses made to the Inquiry about him hitting them excessively. (HIA 18, HIA 25, HIA 31 and HIA 41). He admitted that he did get into a physical fight with a boy, DL 121 who tried

258 RUB 546.
259 RUB 9153.
260 Day 68, p.31 ,Lines 16 – 20.

to defy him by leaving his classroom when he had told him not to. When questioned at the Inquiry hearing DL 149 said BR 3 talked to him and the boy about the incident but he was not admonished and he was given no advice about how to manage such situations in the future. We consider this another example of a young and inexperienced member of staff being expected to deal with challenging behaviour from teenagers with limited guidance and support.

279 DL 149 stated that at times during after-school sporting activities he had to intervene between boys to calm down situations such as claims about unfair tackles but denied ever being physically aggressive with boys during games or punishing them for their failure to win games. HIA 31 described how he experienced being taught to play Gaelic by DL 149:

> "..If you didn't get the ball or do what he told you he would kick you in the backside or hit you on the back of the head with his fist or he would put his knee in your back. He used to sweep your feet from under you to make you fall. He did it to all the boys."[261]

280 Although it is clear that witnesses valued the sporting activities in Rubane we consider that some of the behaviour displayed during such activities contributed to reinforcing the overly physical and macho culture in the home. We also accept from the evidence we heard that on occasion some brothers and lay staff who were taking part in matches got involved in the heat of games and in some cases competed with boys to the extent that they were overly physical and used their superior physical power to score points or assert their control.

281 The final example of a lay member of staff about whom we received allegations of physical abuse is DL 1. DL 1 commenced work in Rubane in 1968/9 as a teacher of geography, maths and RE, and went on to be appointed as vice principal and then principal of the school. DL 1 confirmed to the Inquiry that he used corporal punishment in the school, such as slapping boys, but stated that he would also use other punishments such as making boys stand in the corridor. In his statement to the Inquiry he stated "I never punched a pupil in my life".[262] However, five witnesses HIA 104, HIA 18, HIA 41, HIA 170 and HIA 222 gave consistent accounts of DL 1 punching them in the stomach and the lower body.

261 RUB 915.
262 RUB 5529.

282 While we do not accept each and every allegation about physical abuse by lay staff we are satisfied from the consistent evidence we have heard that some members of lay staff resorted to excessive force to maintain discipline. We are satisfied that the brothers were aware of and tolerated this behaviour and in doing so put the boys at risk of harm.

Bullying by other boys

283 It is clear from the evidence of a number of witnesses that a considerable amount of physical fighting and bullying went on between the boys. This is not surprising, given the age and stage of the boys, the experiences some of them had before they were admitted to Rubane and the overly physical approach to discipline displayed by some brothers and lay staff. On one occasion the fighting between boys led to one boy HIA 31, being stabbed in the back by another boy and having to receive hospital treatment.

284 A witness put forward by the Order, DL 244, stated:

> "Bullying was an issue: as a young boy you got bullied, as an older boy you bullied. We just came through the system."[263]

285 HIA 259 described a hierarchy amongst the boys and that the lower down the ranks the more vulnerable a boy was:

> "The more you were down the ranks the more you got bullied. This was the pecking order in the home and there was a code between the boys, you never told on anyone or grassed them up you would have got the life kicked out of you."[264]

NL 122 described in his oral evidence how on his first day in Rubane he got into fights because boys were trying to bully him and other boys that had transferred with him from Nazareth Lodge to Rubane. HIA 64's brothers followed him to Rubane and he said he did his best to look after them: "I carry more scars for them than I do for myself".[265]

286 Some witnesses indicated that the brothers knew about bullying between boys and turned a blind eye to it. HIA 25, who described a system of chalet bullies and admitted he was one of them, suggested that the brothers would tell the bullies to sort things out, for example if the younger boys were fighting.

263 RUB 1488.
264 RUB 681.
265 RUB 548.

287 We accept that fighting and bullying behaviour are not uncommon in male residential establishments and accept the accounts from brothers and lay staff about how they intervened to stop fights between boys. However, it is clear, as outlined above, that physical aggression was used by staff as a means of establishing and maintaining control and we consider this approach would have reinforced such behaviour by the boys.

Conclusions about physical abuse

288 The Order accepted in its evidence to the Inquiry that there was evidence of excessive physical punishment in Rubane between 1958 and 1962, the time BR 17 was the Brother Director.[266] It also accepted that BR 18 could be overly physical with the boys,[267] BR 77 may not have been suited to the role required of him,[268] and that there were isolated incidents of the application of an excessive number of strokes or of public chastisement, but that these were exceptional.[269]

289 We recognise that during much of Rubane's operation, the use of informal corporal punishment was typical of many day schools and families; it was an accepted part of the culture, and in this respect it could be said that the staff of Rubane were reflecting accepted ways of dealing with misbehaviour. However, we are satisfied that there was widespread resort to excessive physical punishment by some brothers and lay staff. We are convinced by the evidence we have heard that individual brothers, and in later years lay staff, lost control and physically abused boys and that in some cases this violent behaviour amounted to serious physical assault. We accept that, particularly in the early years, the risk of violence from some brothers was ever present and that in many instances the violence was random and unpredictable. **We consider that such behaviour was a consistent feature of life in Rubane up until at least the early 1980s and that it amounts to a systemic failure by the Order to keep children free from abuse.** We found the accounts of Brother Directors using excessive violence against boys particularly concerning, since as the officer in charge their behaviour would have set the tone for the home and for other staff and boys. Also, boys treated in a violent manner by Brother Directors would have had no-one more senior to turn to for assistance.

266 RUB 9149.
267 RUB 9151.
268 RUB 9152.
269 RUB 1952.

290 Given the evidence we have heard, we are satisfied that the Order consistently failed to observe the statutory regulations and the Order's rules for the administration of corporal punishment and that unacceptable levels of physical chastisement were administered throughout every decade of Rubane's operation. We are satisfied that the administration of corporal punishment was not limited to the Brother Director and his deputy and that boys were punished in front of other boys. **We consider the way corporal punishment was administered and the excessive nature of some chastisement amount to systemic failings by the Order to keep children free from abuse and to ensure the institution provided proper care.**

291 We acknowledge that BR 2 attempted to manage the behaviour of his staff to reduce inappropriate chastisement of boys, for example intervening to ensure BR 2 did not take his vows[270] but **we consider the tolerance that the Order showed to inappropriate physical behaviour by brothers and staff, which in some cases included serious physical assaults amounted to a systemic failing to keep children free from abuse**.

292 **We consider the Order's failure to report the serious assaults by BR 77 to the police is a reflection of a collusive approach which put the protection of brothers and the reputation of the Order before the protection of vulnerable children. We consider this amounts to a systemic failing by the Order to take all proper steps to prevent, detect and disclose abuse. We also consider Fr McCann's response to the first assault by BR 77 was inadequate and as the diocese's appointment as chair of the management committee we consider this to be a systemic failing by the diocese to take all proper steps to prevent, detect and disclose abuse.**

293 Brothers talked about the lack of preparation and training they had for the work they were required to undertake in Rubane and the excessive hours they had to work teaching, particularly in the early years in the school, organising after school sporting activities and supervising the children in the home. **We consider that the excessive hours brothers had to work, particularly in the early years, and the lack of guidance and effective supervision they received amounts to a systemic failing by the Order to ensure the institution provided proper care.**

270 RUB 1049.

294 We recognise that qualifying training for residential care workers was only beginning to be introduced in the 1970s in Northern Ireland and that it was common before that time for untrained staff to work in children's homes. **However, we consider the lack of support and guidance given to lay staff in Rubane, particularly to those who were clearly having difficulties in meeting the challenges of working with adolescent boys, amounts to a systemic failing by the Order to ensure the institution provided proper care.**

295 We consider that the overcrowding and poor staffing levels which persisted up until the late 1960s and were condoned by the Order, the diocese, and the MoHA were significant contributory factors in staff using excessive physical force to establish authority and maintain discipline over large groups of boys, many of whom displayed challenging behaviour. As stated previously we consider the willingness of the Order, the Diocese, and the MoHA to allow these inadequate conditions to develop and continue for a number of years amounts to a systemic failure to ensure the home provided proper care.

296 Fr McCann said in a statement to police about the assaults by BR 77 that the management committee's position was that corporal punishment should not be used and that anyone bad-tempered or quick-tempered was unsuitable for work with children. We could find no evidence of the management committee agreeing this position or communicating it to staff. Two chaplains, DL 140 and DL 366, were aware of boys being subject to violence in Rubane and both made attempts to intervene in relation to it. We found no evidence that either of these priests shared their concerns with their bishop in his capacity as chair of the Governing Board. We consider that, if they had reported their concerns, the Governing Board might have intervened and required brothers and staff in Rubane to adhere to statutory regulations for the administration of corporal punishment.

297 As previously mentioned, in the report of her inspection of Rubane in May 1955, Ms Forrest recorded that corporal punishment was only occasionally inflicted and none had so far been recorded in that year. Given the evidence we have heard, we have concluded that records were not being maintained as they should have been and that Ms Forrest was given false information about the administration of corporal punishment. BR 2 accepted in his written statement to the Inquiry that there may have been occasions when the official returns about the administration

of corporal punishment "may have been incomplete or inaccurate".[271] **We consider these failings to engage properly with processes set down in regulations to ensure the protection of children amount to a systemic failing by the Order to ensure that children were free from abuse.**

Sexual abuse

298 Fifty-one of the 60 witnesses we heard from alleged they were sexually abused in Rubane by staff and/or by their peers and they also stated that they were aware of other boys being subject to such abuse. The allegations cover the four decades in which Rubane House operated as a children's home and involve abuse ranging from fondling over clothes to anal rape. The alleged perpetrators of the abuse are De La Salle brothers, lay staff, a chaplain, other boys and people from outside the home including a neighbouring farmer, foster parents, visiting priests and a music teacher.

299 We have carefully considered each allegation and related response statements from the Order. It is not the Inquiry's role to make a finding in relation to each allegation and our analysis of the evidence has focused on determining whether and to what extent systemic sexual abuse occurred in Rubane. The Order has suggested that some allegations are exaggerated, lack credibility because they contain factual inaccuracies or are not corroborated. As we have previously indicated we accept that the memories of all involved may be affected by the passage of time and that the emotional content of traumatic events may affect memories and we have taken that into account in our consideration of evidence.

300 The Order received complaints of alleged sexual abuse by brothers in 1958, 1964, 1970 and 1980 and we will consider each in turn and how the Order responded to them.

BR 17

301 The first investigation of alleged sexual abuse in Rubane occurred in 1958 and was prompted by five boys telling the then chaplain that the Brother Director, BR 17 had sexually interfered with them. The chaplain advised the boys to report this to the brothers; the boys told BR 63 who in turn reported it to BR 13. As the allegations were against the director of the community BR 13 referred the matter to the Provincial BR 19. BR 19

271 RUB 1084.

went to Rubane on 11 September 1958 to investigate the allegations and as part of his investigations he interviewed the 39 boys in residence and the brothers.[272]

302 In the notes of his investigation BR 19 recorded that BR 17 admitted applying ointment for scabies on naked boys in his room and telling the boys he could do this because he was acting in the place of their parents. He also admitted to being alone with boys in a car and giving boys individual instruction on morality in his office.

303 BR 19 noted that of the nine boys that "had made mention of having being wronged by [BR 17]" two had left Rubane and therefore could provide no evidence and six had retracted their allegations during the course of the investigation. There is a suggestion that these six boys may have been put up to making the allegations by DL 439, one of the two boys who had already left Rubane.[273]

304 In relation to the last of the nine boys, a boy called DL 480, who was not involved in making the original allegations, BR 19 recorded that he was adamant that BR 17 had sexually interfered with him in a car and said he was prepared to repeat his allegation in front of BR 17 and a priest. BR 19 recorded in his notes "This cannot easily be ignored!" and in response to BR 17's denials of wrongdoings he recorded, "One is left with a slight doubt".[274]

305 BR 19 made a brief note of his interviews with the other brothers and recorded that BR 15 said he could not credit that BR 17 was guilty and that the boys "enjoyed telling yarns" to BR 13'[275] and that BR 14 said the "more I think it over the more I doubt it".[276]

306 BR 19 wrote to BR 17 to inform him of the outcome of his investigation and he stated in relation to the boy who persisted in his allegation:

> "Don't for one moment think I am accepting his word against yours, but you will readily agree that it is very unfortunate but the charge still stands."[277]

307 He went on to state that it was imprudent of BR 17 to strip boys for the purpose of applying treatment directed by the doctor and wrong of him

272 RUB 199-200.
273 RUB 201-202.
274 RUB 201.
275 RUB 5488.
276 RUB 5488.
277 RUB 5495.

to take boys to his room for the purposes of applying that treatment. He added that it was very unfortunate that BR 17 told boys he was entitled to touch them because he was taking the place of their parents and commented that "they have been otherwise instructed by the Priest",[278] which suggests that the chaplain's conversation with the boys who made the first allegations was a detailed one and went beyond merely advising them to refer their concerns to the brothers.

308 BR 19 instructed that in future no brother should travel alone in a car with an individual boy on any occasion; a glass panel should be inserted in the office door in the school and under no circumstances should any boy be allowed to enter a brother's bedroom. These instructions for future behaviour were already set down in the Order's rules and we noted that BR 19 gave no written admonishment to BR 17 for his lack of adherence to the Order's rules. It is clear from evidence from witnesses who were in Rubane after this time that some brothers continued to ignore the rules about brothers being alone in a car or in their bedroom with boys.

309 BR 19 finished his letter with "I advise that no reference be made at any time or to anybody regarding this enquiry. It is best forgotten."[279] It appears this advice was accepted as there is no mention made of the investigation or even that BR 19 visited Rubane in the Events of Importance Log for 1958[280] or History of the Home.[281] This meant that if MoHA officials had considered these documents during inspections they would not have been alerted to the investigation. There was also no reference to the investigation or the Provincial's visit in the minutes of the next meeting of the governing board held on 4 February 1959.

310 The matter did not rest there, because on 14 November 1958, BR 19 received a letter from Canon Rice of Portadown stating that DL 439, the former resident of Rubane referred to above, had told his father that BR 17 had sexually abused him. DL 439 informed his solicitor of the allegation, who in turn told Canon Rice, who was also his client, about it. BR 19 travelled to Dundalk on 18 November 1958 to discuss the matter with Cannon Rice and then went to Rubane on 20 and 21 November 1958 to investigate the allegation. He interviewed DL 439 in the presence of his two uncles and a curate and also interviewed the other boys involved in

278 RUB 5485.
279 RUB 5485.
280 RUB 10101-10103.
281 RUB 11817/8.

making the original complaint, some of whom he collected from Belfast because they had by then left Rubane. He recorded the outcome of his interview of DL 439 in a letter dated 22 November 1958 to the Br Assistant:

> "After six hours he finally confessed that the charge against [BR 17] was false. I know that we really used 'third degree' in getting the confession from him and only when I told him that I would keep him overnight did he finally confess. This is not too satisfactory and one is left in some doubt."[282]

311 He also added:

> "Unfortunately according to English law a case of this nature is supposed to be investigated by the police. I don't know if English law obtains in the Six Counties. Probably it does. We can only keep praying."[283]

312 Subjecting a boy who has made allegations of sexual abuse to six hours of questioning and threatening to keep him overnight in the premises in which the alleged perpetrator of the abuse was the Brother Director was totally unacceptable. It is clear from BR 19's remarks that he was well aware that what he was doing was unacceptable, but that he felt justified in treating the child as he did and believed he could do so with impunity.

313 There is no record that BR 19 referred the matter to the police, the MoHA or the governing board, and despite recording twice in writing that he was left in some doubt about BR 17's conduct he allowed him to remain as Brother Director of Rubane. There is also no evidence that BR 19 gave BR 17 any further formal warning about his behaviour as a result of the allegations by DL 439 or that he increased his monitoring of BR 17's behaviour and directorship.

314 The Inquiry received evidence from seventeen witnesses who were resident in Rubane at the same time as BR 17 and seven of those told the Inquiry that they had been sexually abused by him. This abuse ranged from putting a boy on his knee and fondling his genitals while watching television in a darkened room,[284] and interfering in a similar manner with a boy while transporting him in a car,[285] to attempted anal and oral rape.

282 RUB 5494.
283 RUB 5494.
284 HIA 247, RUB 820.
285 HIA 159, RUB 791.

HIA 252 recounted four occasions when he was taken from his bed at night by BR 17 and sexually abused in BR 17's bedroom. He described being made to masturbate BR 17 and how on one occasion when BR 17's attempts at anal penetration were unsuccessful he made HIA 252 lie face down on the bed and he rubbed his penis up and down HIA 252's back until he achieved ejaculation.[286] HIA 252 told the Inquiry:

> "...I was living in fear of being taken out of the room for years; the fear was a form of mental abuse too."[287]

315 In his oral evidence to the Inquiry HIA 252 referred to seeing a boy called DL 439, who was the subject of the 1958 investigation, going into BR 17's room and BR 17 sitting with his arm around DL 439 in the television room. HIA 252 described the latter as "something you would have maybe seen with a fella and a girl in the cinema."[288]

316 HIA 183 told the Inquiry about BR 17 bringing him and three boys into his office, making them strip naked and face the wall and then face him. He also recounted BR 17 taking him to his bedroom on around six occasions, telling him to take his pants down and then on the pretence of examining him, fondling HIA 183's penis until he aroused him.

317 HIA 183 was the only witness who remembered being talked to by a "Head Brother" in 1958, which was the time that BR 19 talked to the boys in Rubane as part of his investigations into the allegations against BR 17. HIA 183 explained that he did not tell this brother about being abused and instead said he was happy at Rubane because he feared that if he told the truth he would be made to leave Rubane and he had nowhere else to live.

318 HIA 247 recounted being fondled and interfered with by BR 17 while watching television and being fondled in his bed in the dark of night but not being able to see which adult was doing this to him. He also stated he was aware of other boys being interfered with in a similar way in their beds. In response to the Order's suggestion that the activity in the bedroom may have been brothers checking on bed wetters HIA 247 responded "I didn't wet the bed, and what they were doing inside the bed wasn't checking the sheets were wet."[289]

286 HIA 252, RUB 663.
287 RUB 633.
288 Day 55, 6 October 2014, p.177.
289 Day 57, 8 October 2014, p.45.

319 The Inquiry found the evidence of HIA 399 and that of his brother HIA 261 about the sexual abuse they suffered from BR 17 particularly revealing. The brothers were admitted to Rubane in March 1960, almost sixteen months following BR 19's decision to take no further action in relation to the second complaint of sexual abuse against BR 17.

320 HIA 399 gave a very clear and detailed account about being sexually abused on a regular basis, once or twice a week, by BR 17 in BR 17's bedroom, his office, a car and workman's hut. HIA 399 explained that he had no previous sexual experience, so did not know what was happening and that, although he cried during the abuse,[290] that did not deter BR 17. He explained how on one occasion BR 17 brought him and his brother to visit their grandmother in Dublin for an overnight stay and BR 17 manoeuvred the situation so that he shared a bed with HIA 399 and sexually abused him.[291] He also told the Inquiry that BR 17 arranged for HIA 399 and HIA 261 to stay with his own family in Dundalk; HIA 399 now thinks this may have been an attempt to establish a fostering situation.[292] When the arrangement fell through, the brothers were returned to Rubane and were told by BR 17 to say they had been staying with their father but it had not worked out.

321 HIA 399 explained that BR 17 would give him gifts and tell him to pretend that they came from his father and on occasions gave his father money, including £40, to pay off debts.[293]

322 HIA 399 indicated that he thought some of the brothers might have been aware he was being sexually abused by BR 17 and this is supported by the account of his brother, HIA 261. He told the Inquiry that on one occasion a brother pointed out sarcastically that a parcel for HIA 399, which was supposed to have been sent to him from Canada by an uncle, was not stamped.[294]

323 When BR 17 turned his attentions to HIA 261 and began fondling him, HIA 261 told DL 140 in confession that he was being sexually interfered with by a brother. DL 140 advised him to tell the head brother and HIA 261 said he told him that the head brother knew. He explained when giving oral evidence that he thought the priest would understand from this that it

290 RUB 865.
291 RUB 866.
292 RUB 866.
293 RUB 866.
294 RUB 702.

was the head brother who was abusing him. There is no evidence of what action, if any, was taken by DL 140 about this allegation.

324 Father Bartlett explained on behalf of the Diocese of Down and Connor that because DL 140 was absolutely bound by the law of the Church to observe the seal of the confessional he could not tell anyone what HIA 261 told him. HIA 261 did not indicate that he received any further guidance or support from the priest and there is no evidence to suggest that DL 140 alerted the bishop in even a general manner about the possible sexual abuse of boys in Rubane.

325 HIA 399 and HIA 261 left Rubane to return to their family in July 1962 and BR 17 left Rubane in August 1962, but he continued to maintain contact with the family and to provide them with financial support. HIA 261 described how on such a visit to the family home BR 17 stayed overnight and slept with him in a single bed and proceeded to touch HIA 261's genitals and attempted to have oral sex with him.

326 HIA 261 summed up the impact of the abuse on him:

> "It wasn't just the physical aspect of the abuse that affected me; it messed with your mind. I remember thinking I hope when I grow up it isn't compulsory the way mass and prayers were compulsory. I was thinking I hope this isn't something all adults do because it doesn't seem right at all."[295]

327 We are satisfied that BR 17 sexually abused boys in Rubane over a number of years. We consider BR 19's handling of the investigation in 1958 was gravely deficient, in particular his failure, despite his doubts about BR 17's behaviour and honesty, to report the matter to the police, to the governing body, or to the MoHA as he should have done.

328 BR 17 remained in post for almost four more years until he was moved on 1 August 1962 to work in a primary school in Downpatrick. We are aware from documentation provided by the Order that BR 17 sexually abused children while working in Downpatrick. Had BR 19 reported the 1958 allegations to the civil authorities as he should have done, then it may well be the case that BR 17 would have been brought to justice at that time, and so have been unable to abuse more children in Rubane and in Downpatrick. **We consider BR 19's decision, as Provincial, not to report the allegations as he should have done was a systemic failure by the Order to take all proper steps to prevent, detect and disclose abuse.**

295 RUB 704.

329 Although the Order provided the Inquiry with handwritten notes that BR 19 made during his investigation of BR 17 and related correspondence, it is clear from the evidence we heard from the Order that Provincials did not as a matter of course leave confidential files to make their successors aware of previous investigations into the conduct of brothers. Br Francis Manning addressed this issue in his oral evidence to the Inquiry:

> "I find it difficult to rationalise why on leaving office a Provincial would not brief his successor on abuse issues so as to build a knowledge base within the Order. There is no doubt that the Order, like many organisations, must have felt a great sense of embarrassment about the complaints, and this led to a certain element of secrecy, which was unhelpful in educating the Order to the risks of such offending."[296]

330 We agree that this element of secrecy was unhelpful to the Order and unsatisfactory in relation to ensuring the protection of children.

BR 14

331 The second recorded incident of alleged sexual abuse being investigated in Rubane relates to BR 14. A number of witnesses to the Inquiry alleged BR 14 physically abused them but none alleged he sexually abused them. However, HIA 252 described him sitting with boys in his knee and fondling them in the television room and removing boys from their beds at night.[297]

332 HIA 262 recounted being sexually abused by a brother on his first night in the main house in Rubane when he was aged 11 years. He said the brother who abused him told him he was protecting him from older boys and then proceeded to sexually abuse him, including making him administer oral sex. Commenting about this allegation the Order point out that BR 14 was located in the main house at this time.[298] HIA 97 made allegations about a BR 25, including that he pulled his testicles in the shower, but accepted that he was confused about the name of the brother and the Order has suggested, given the details provided by HIA 97, many of which concern behaviour on the hurley pitch that it may be BR 14 he is talking about. HIA 160 told the inquiry that BR 14 was known "as a dirty old man".[299]

296 Day 78, p.90.
297 RUB 663-664.
298 RUB 9164.
299 RUB 861.

333 Although the Inquiry received no direct allegations about sexual abuse by BR 14 it did examine and will now consider how allegations of sexual abuse against BR 14 were dealt with by the Order, because of the significance of how the Order dealt with these allegations and communicated about them with relevant parties.

334 In 1964, DL 13, then aged 13 years, was placed in Rubane by County Down Welfare Authority for non-school attendance. He told his brother on a visit home that he did not want to return to Rubane because he was being sexually abused by BR 14. His family reported this to County Down Welfare Authority who referred the matter to the police and to the MoHA. DL 13 made a statement to the police on 19 August 1964 in which he alleged he had been sexually abused by BR 14 on three occasions.

335 County Down Welfare Authority informed BR 6, the then director of Rubane, about the allegations, and he in turn informed the Provincial BR 19. BR 19 asked BR 6 to meet with BR 14, who was on holiday in the South of Ireland, to discuss the allegations. BR 6 did so and when BR 14 refused to return to Northern Ireland to face the allegations BR 6 told him to go to the Irish headquarters of the Order at Castletown in County Laois to discuss the matter with BR 19. This meeting took place and Br Pius in his statement to the Inquiry on behalf of the Order stated that BR 14 admitted to one incident of 'immoral conduct' with one boy when he had drink taken, and consequently BR 19 advised him to seek a dispensation from his vows which he agreed to do. BR 14 remained in Castletown until his dispensation was granted, which meant that the police in Northern Ireland were unable to prefer charges against him as he was outside their jurisdiction. The dispensation was granted and BR 14 left the Order on 9 October 1964.

336 Miss Forrest of the MoHA had at least two meetings with the police and with the Newtownards District Welfare Officer to discuss the matter prior to meeting with BR 6 in Rubane on 7 September 1964 to discuss it. According to the Royal Ulster Constabulary (RUC) minute dated 9 September 1964, Miss Forrest was at that stage:

> "endeavouring to assist the Ministry to decide whether or not the school at Rubane should continue to be recognised as an approved voluntary school with particular emphasis on ascertaining whether this was an isolated incident or whether more boys might have been involved."[300]

300 RUB 1013.

337 Ms Forrest made a note of these discussions and recorded that the police had interviewed boys named by DL 13 who had left Rubane but who he presumably suggested were aware of BR 14's behaviour and that "they denied all knowledge of such a thing".[301]

338 BR 19 went to Rubane on 18 September 1964 to investigate the allegations and in a subsequent written report to the MoHA, dated 19 September 1964,[302] he explained that he told the brothers that a serious charge had been made against a brother and that any information they could give would be appreciated; it appears from his report that no information was provided. He also reported that since the boys were unaware of any untoward incident he decided it would be more discreet to refrain from carrying out an individual investigation:

> "which would serve no useful purpose but which would unquestionably undermine the good relationship between Brothers and boys and result in rousing their curiosity."[303]

339 BR 19 informed MoHA officials that BR 14 admitted to a single incident with one boy only and assured them that in response to that admission the Order took immediate measures to ensure that BR 14 would never again be allowed to have any contact with boys in any school. He also stated that he could personally certify that the remaining staff in Rubane were thoroughly reliable and in every respect suitable to carry out their duties.[304]

340 BR 19 and BR 6 met with Mr Parkes and Ms Forrest in Stormont on 21 September 1964 to discuss the matter and, on the basis of the information provided, the MoHA concluded that no further action was necessary. With reference to this meeting, BR 19 recorded in a file note that it had been agreed that his report about his investigation would be kept confidential and that no further action would be taken.[305] Mr Parkes of MoHA wrote on 30 September 1964 to an RUC Chief Inspector asking for a full report of the police actions and findings in the case so that the Minister could be kept as fully informed as possible, given that the case could lead to repercussions, and assured him that this report would be treated as strictly confidential.[306] There is a note to show that the Minister had sight of these papers on 25 November 1964.[307]

301 RUB 1018.
302 RUB 1020-1022.
303 RUB 1021.
304 RUB 1020-1022.
305 RUB 1030.
306 RUB 1023.
307 RUB 1027.

341 Following the meeting with BR 6 on 21 September 1964, Miss Forrest contacted Down Welfare Authority and informed them that the Provincial had informed the Ministry in writing that the incident involving DL 13 was an isolated one and that he would ensure that BR 14 would not be put in a position in the future where similar occurrences could take place. On the basis of this information the official recorded that he told Miss Forrest that in the circumstances no further action appeared necessary.[308]

342 In his report to the MoHA about his investigation of this case and subsequent action BR 19 did not mention his previous investigation into allegations of sexual misconduct against BR 17 and there is nothing to suggest that he raised this in his discussions with officials. We agree with Dr Hilary Harrison's conclusions on behalf of the DHSSPS, in her statement to the Inquiry of 19 September 2014, that if the Provincial had shared that information:

> "…the Ministry and the police might have questioned the conclusions about the isolated nature of the 1964 incident."[309]

343 Dr Harrison accepted that the MoHA was aware of previous allegations about sexual abuse at St Patrick's in 1948 but, since it was judged at the time by an ecclesiastical commission established to investigate them that they were unfounded, it was unlikely that the officials dealing with the case of BR 14 would have been aware of the 1948 case.

344 Dr Harrison concluded:

> "The Department believes that the actions of the Ministry were consistent with both the information they were given and the knowledge about child sexual abuse that existed at the time."[310]

345 We agree with this conclusion and accept that it was reasonable on the basis of the information provided by the Provincial to the Department that it decided the matter had been properly handled by the Order. Dr Harrison also pointed out that this incident prompted the MoHA to be firmer with BR 6 about the need for adequate staffing in Rubane. On 18 November 1964, with reference to proposed new accommodation developments at Rubane, Mr Parker wrote to BR 6 and stressed the need for the home to be properly staffed and made the point:

308 RUB 9321
309 RUB 1895.
310 RUB 1894.

> "Recent events have given added point to our feeling that where such a small staff have so much to do for so many children the development of a satisfactory relationship of trust and confidence between individual children and members of staff is virtually impossible."[311]

346 During the gathering of material for this module the Inquiry asked for a copy of BR 14's letter seeking dispensation from his vows and any related documentation. The Order made arrangements to get copies of these documents and submitted them to the Inquiry and it became clear from this documentation that BR 14 had admitted to more than a one-off incident. In his letter seeking dispensation he admitted to "grave immoral actions with a number of boys".[312] BR 19 countersigned BR 14's letter and described him as "a positive danger to young people". In a separate letter to Brother Vicar General in Rome about the matter BR 19 stated "during the past three years he has interfered with boys, a couple each year."[313] BR 19's letter is dated 12 September 1964, five days before he submitted his report to MoHA officials assuring them that BR 14 had only admitted to a one-off incident with one boy.

347 We are satisfied that BR 19 deliberately mislead the MoHA by withholding information he had about the extent of BR 14's sexual abuse of children and by saying this incident at Rubane was a one-off. He should have revealed the full extent of BR 14's offending to the MoHA and had he done so, it could well have prompted a thorough investigation into Rubane and a reappraisal of the home's suitability to continue as a children's home. **We consider that the deliberate suppression by BR 19 of the extent of BR 14's sexual abuse of other young boys was a systemic failure on the part of the Order to take all proper steps to prevent, detect and disclose abuse.**

348 Dr Hilary Harrison provided a supplementary statement to the Inquiry on 3 December 2014 on the basis of this new evidence and concluded:

> "The Department believes that as consequence of vital information having been withheld in relation to 1964 investigation, an opportunity which had the potential to lead to earlier recognition of the vulnerability of children in institutional care was lost."[314]

311 RUB 10129.
312 RUB 7159.
313 RUB 7160.
314 RUB 5963.

349 It appears that Down Welfare Authority informed Belfast Welfare Authority about the matter, as its Chief Welfare Officer visited Rubane in early September seeking assurances in relation to it. BR 6 wrote to BR 19 about this visit and commented:

> "As far as I can gather the Welfare is pretty sympathetic towards the case and are looking for a guarantee that the home is a salutary place for boys to be sent to."[315]

350 Although it is positive that the Chief Welfare Officer sought this reassurance it appears that he accepted it to such an extent that he did not share information about the matter with his social work colleagues. Mr Bunting in his evidence explained that he had only heard about the case of BR 14 as part of the information he received in relation to this Inquiry. We consider this lack of communication to be a serious omission and note that the HSCB acknowledged this in its closing written submission to this module.

351 The HSCB also pointed out in its closing written submission that because the full details of the case were not shared with the welfare authorities the possibility of institutional sexual abuse of children was not recognised by social workers in Northern Ireland before 1980.

BR 15

352 The third allegation of sexual abuse in Rubane that is investigated by the Order is a complaint made by HIA 36 that he was sexually abused by BR 15. The details of how this complaint was made are unclear; BR 6 who was the Brother Director at the time of the complaint indicated in a police interview that he thought the complaint might have come from a social worker. However, in his evidence to the Inquiry HIA 36 said he thought he told his mother and that she contacted BR 6 and possibly DL 140 the chaplain. The Order has no records of any investigation of the complaint but informed the Inquiry that the then Provincial, Br Maurice Kirk, visited Rubane between 13 and 15 November 1970 and three days later on 18 November 1970 BR 6 visited HIA 36's mother. On 26 January 1971 BR 6 met Br Maurice in Downpatrick and although there are no records of the content of that meeting, BR 15 was subsequently moved to Finglas on 31 January 1971. The Order told the inquiry that the Provincial was faced with a strenuous denial of any wrongdoing by BR 15 and that HIA 36's mother had indicated that her son's word was not reliable. Br Maurice

315 RUB 1029.

nonetheless decided to move BR 15 from Rubane as a precautionary measure. **There is no record of this alleged abuse being reported to the police, the MoHA or the Board of Governors and we consider this to be a systemic failing by the Order to take necessary action to enable the investigation and prosecution of criminal offences involving sexual abuse.**

353 The Inquiry heard from 34 witnesses who were resident in Rubane during the time BR 15 worked there and ten of these witnesses,[316] including HIA 36, alleged they were sexually abused by BR 15.

354 The alleged abuse ranged from being kissed,[317] fondled and masturbated,[318] being made to engage in simulated sex[319] to anal rape.[320] HIA 36 described how in his first night in Rubane, when he was 11 years old, BR 15 brought him to his bedroom, made him undress and forced him to masturbate him. HIA 36 recalled:

> "I felt dirty and disgusted and wanted to get out of the room. I started to cry and he told me if I didn't stop he would give me something to cry about."[321]

355 HIA 36 also described being abused by BR 15 alongside another boy DL 271, known as "half pint" because he was small in stature. HIA 56 told the Inquiry that on one occasion he went to BR 15's bedroom and interrupted him having sexual activity with DL 271.[322]

356 The Order has accepted that HIA 36 was abused by BR 15 and they have also accepted he sexually abused HIA 147 and have paid HIA 147 compensation for that abuse.

357 HIA 36 was one of the few witnesses who reported the abuse he was experiencing, and although this eventually led to BR 15 being removed from Rubane he told the Inquiry about the inappropriate responses he received when he initially reported the abuse. He recalled the chaplain, DL 140, telling him that BR 15 was unwell and would be moved and DL 115, a house parent advising him to put the abuse behind him and forget it. HIA 36 also described how, when he told his mother about

316 HIA 427,HIA 160, HIA 64, HIA 183, HIA 225, HIA 26, HIA 511, HIA 147, HIA 56 and HIA 36.
317 HIA 427.
318 HIA 160, HIA 225, HIA64 and HIA 138.
319 HIA 56.
320 HIA 26.
321 RUB 477.
322 RUB 528.

the abuse, she initially refused to believe him but he explained that he understood her reaction because she would have thought the brothers were beyond reproach.

358 In addition to these ten witnesses, HIA 279 recalled a brother fondling him in his bed at night and in the brother's office. He was unsure of the name of the brother but remembered that he was in charge of the clothing store, which was BR 15's responsibility towards the end of HIA 279's time in Rubane. Given that HIA 279's account of the abuse is similar to that described by another witness[323] we are of the view that HIA 279 was abused by BR 15. Since HIA 279 left Rubane on 24 December 1956 this would mean BR 15 commenced sexually abusing boys soon after his arrival in Rubane on 17 November 1956.

359 Five other witnesses[324] gave evidence about observing BR 15 sexually interfering with boys under their clothing while watching television or films in a darkened room and three of them[325] referred to BR 15 interfering with boys at night in the dormitories.

360 We are satisfied that between 1953 when BR 17 arrived in Rubane and 1971 when BR 15 left, 18 years in total, at any one time there was at least one brother sexually abusing boys. We are also satisfied that for a five-year period from 1957 to 1962 when these three brothers were working together in Rubane, as part of a small community of brothers, they were all sexually abusing boys. In its submissions to the Inquiry the Order has accepted that BR 17, BR 14 and BR 15 were sexually abusing boys in Rubane between 1956 and 1962.[326]

361 One of the most concerning aspects of the behaviour of these brothers is that at the same time as they were sexually abusing boys they were also very physically aggressive in the home, including towards boys they were sexually abusing. Exploitation of the power differential between adults and children is a common feature of sexual abuse of children, but this was particularly the case in relation to these three brothers who reinforced that differential with frequent displays of physical violence towards boys.

362 For example, HIA 183, who was sexually abused by BR 17, described receiving a severe beating from him for saying he was learning a hymn

323 HIA 183.
324 HIA 252, HIA 59, HIA 390, HIA 244 and HIA 385.
325 HIA 252, HIA 385 and HIA 244.
326 RUB 9163.

rather than Latin and observing BR 15, who also sexually abused him, hitting a boy with a bamboo cane until blood poured from the boy's face.[327]

363 HIA 247 told the Inquiry that he told no one that BR 17 was abusing him because he was frightened of crossing him. HIA 56 said he told no one about being abused by BR 15 because although he had not been hit by him he had seen how he hit other boys. HIA 399, who was sexually abused by BR 17, described him beating boys until the sweat poured from him.

364 Some boys who managed to tell another adult about the abuse they were experiencing received an aggressive or hostile response. For example, HIA 36 said he was caned by BR 6 when he told him he was being abused by BR 15. HIA 252 recalled that when he told DL 411 of the Welfare Authority about being sexually abused by BR 17, DL 411 shouted at him and said he was lying and that the brothers were religious men who wouldn't do such things. HIA 252 explained that as a result of DL 411's reaction: "I did not tell anyone else what had happened to me because I thought that they would not believe me and that it would be a waste of time."[328]

365 Witnesses also described grooming behaviour by the brothers and the confusion that created for them. HIA 399 told the Inquiry of his confused feelings about BR 17's behaviour:

> "I obviously had mixed feelings towards BR 17 as I knew he was buying gifts to keep me sweet but I hated what he was doing to me and did not feel I could talk to anyone about it."[329]

HIA 261 described his feelings when BR 17 bought him a second-hand bike after sexually abusing him; "I remember feeling guilty as if I was playing the game".[330]

366 Another witness who described feeling guilty about abuse he suffered was HIA 152. HIA 152 described to the Inquiry how he was groomed and sexually abused by BR 65 who worked in Rubane for a short time alongside BR 15 and he explained how he was left feeling the abuse was his fault:

> "I always felt it was my fault because I never tried to stop it, or put up a fight but I suppose I was too young to know what to do."[331]

327 RUB 617.
328 RUB 664.
329 RUB 867.
330 RUB 704.
331 RUB 603.

367 A number of witnesses described occasions when they were subjected to sexual assaults by a brother when other brothers were present and also took part in the abuse. We have carefully considered all the evidence relating to these allegations. Given that the evidence we have heard during this Inquiry, as well as the experience of cases heard in criminal courts, suggests that sexual assault is almost invariably perpetrated when the abuser and the victim are alone together, such allegations have to be regarded with considerable circumspection. We have given very careful consideration and we are not persuaded to the requisite standard of proof that brothers sexually assaulted boys in front of other brothers in Rubane.

Did other brothers know that brothers were sexually abusing boys?

368 However, there is the question of how much brothers who were sexually abusing boys knew about the sexual abuse being perpetrated by their fellow brothers. Br Pius in his evidence to the Inquiry explained that the communities of brothers were generally small, of three to ten brothers, and that there was strict timetable which meant "it was almost impossible for a Brother to do anything without the Community knowing about it."[332]

369 We do not know whether the three brothers who were sexually abusing boys in Rubane at the same time were aware of each other's behaviour, discussed it or co-ordinated it. However, given the small number of brothers in the community in Rubane, the close living and working conditions and the talk that went on between the boys about the abuse we consider it probable that the three brothers were aware of each other's activities and took some comfort that their sexual misconduct was unlikely to be challenged by like-minded brothers. We consider that BR 14 and BR 15 could have taken particular comfort from their knowledge that the Br Director, BR 17, was sexually abusing boys and therefore would be likely to overlook their behaviour if it was reported to him.

370 Although the most serious sexual abuse was carried out in secrecy, and usually in the brother's room, it is significant that brothers were prepared to engage in covert sexual activity such as manual stimulation of boys when other boys were present in the television room and at night in the dormitories. This was an era when room lights were commonly turned off when the television was on, so they had the advantage of carrying out their abuse in darkness, as would have been the case when they interfered with boys at night in the dormitories.

332 RUB 177.

371 However covert or discreet this behaviour was, it was being conducted in public places in front of a number of boys and it is clear from witnesses that the boys knew what was going on. The brothers therefore ran a significant risk of their behaviour being discovered. That they were prepared to run that risk suggests that they felt confident their behaviour would not be challenged or reported and that this confidence allowed them to abuse boys on a regular basis. HIA 279 commented in relation to being interfered with by a brother, who we take to be BR 15, at night in the dormitory and in his office:

> "He never threatened or warned me not to tell anyone about these incidents. He acted as if it was normal behaviour."[333]

372 We also consider it reasonable to assume that BR 15 and BR 14 would have taken some comfort from the way the allegations about BR 17 were dealt with and that he was allowed to remain in post. We noted that in BR 19's notes of his investigation into the allegations about BR 17 he recorded that the brothers had initially "seemed to assume the Dtor. [Director] was guilty"[334] which suggests that they may have been aware of BR 17's behaviour with the boys. He also recorded that BR 15 gave BR 17 a hint that there were some serious charges against him, which might indicate some form of collusion between the brothers. As previously referred to during the first investigation into BR 17's behaviour, both BR 15 and BR 14 told the Provincial they could not believe the allegations against him. The Provincial recorded and gave weight to these assurances, so we have the situation of two brothers who were sexually abusing boys supporting a senior brother who was accused of doing so.

373 The other suggestion of collusion is that it was BR 15 who sent HIA 152 to BR 65's room and BR 65 went on to groom and sexually abuse HIA 152.

374 The low level of staffing, particularly in the early days before the introduction of the chalet system, may also have contributed to creating an environment that enabled sexual abuse to go unobserved by other staff, since it meant brothers were often working alone with the boys in the evening. In his evidence to the Inquiry BR 2 said that he would not have been in the television room with another brother because he would be getting on with other work such as preparing lessons in his room while the boys were being supervised.

333 RUB 899.
334 RUB 5491.

375 The low staffing level also meant that brothers would often work alone, supervising boys showering and in the dormitories, and even when lay staff were employed the brother attached to each chalet remained responsible for supervising night care.[335] BR 2 accepted in his evidence to the Inquiry that the problem some boys had with enuresis gave BR 15 a reason for being in the dormitories at night without raising suspicion among other staff.[336]

376 The inadequate accommodation in Rubane also meant that the brothers lived in close proximity to the boys' dormitories, which would have enabled ready access to the boys and made it easier for brothers to take boys to their bedrooms. This close proximity may also have meant that brothers who had a propensity towards sexually abusing boys were in the situation where the temptation to do so was high.

BR 1

377 The next time that allegations of sexual abuse were formally investigated in Rubane is in 1980. On 3 April 1980 a social worker, DL 524, employed by the EHSSB had a discussion with former residents of Rubane in the light of reports that were emerging about sexual abuse in Kincora. Kincora was a children's home in Belfast which we consider in Chapters 23 to 27 of this report. The former residents made references to inappropriate sexual behaviour by the then Director of Rubane, BR 1. DL 524 referred this matter to her seniors, who then informed Bishop Philbin as the chairman of the board of governors of Rubane and the police. Bishop Philbin suspended BR 1 on 12 April 1980 and subsequently the then Provincial, Br Columba Gallagher, arranged for BR 1 to move to a secretarial post in Dublin. The Order stated in its evidence to the Inquiry that Br Gallagher interviewed BR 1 at length on a number of occasions about the allegations but he strenuously denied them.[337] BR 1's explanation for the allegations was that in the absence of trained medical staff he undertook "medical examinations" of new entrants to identify any problem with nits, or body lice and to notice any birth marks, tattoos or scars by which they could be readily identified.[338]

378 As mentioned previously, as a result of the allegations against BR 1 the police interviewed 124 boys who were resident in Rubane between 1977

335 RUB 133.
336 RUB 1078.
337 RUB 189.
338 RUB 189.

and 1980. Twenty-nine boys made allegations of a sexual nature about BR 1 and the police brought charges against him. However, BR 1 developed a malignant tumour of the spine and the Public Prosecution Service decided not to pursue proceedings against him. BR 1 underwent major surgery and had a remission for a number of years before dying from a malignant tumour of the brain in October 2000. The Order has settled a number of civil claims made against BR 1.

379 The Inquiry heard evidence from eleven witnesses who were resident in Rubane at the same time as BR 1, seven of these told the Inquiry about inappropriate sexual behaviour by BR 1. HIA 362 told us that BR 1 gave him a "medical examination" when he was admitted to Rubane during which BR 1 told him to undress so that he could check for rashes and that once he was undressed BR 1 groped and fondled his genitals. HIA 362 said that on subsequent occasions BR 1 used the pretence of tickling him and playing with him in order to touch him on the backside.[339] DL 40 was interviewed by the police in 1980 and told them that BR 1 rubbed his chest inside his shirt and patted him on the bottom but always over his trousers.[340] HIA 104 described BR 1 trying to put his hand down the front and back of his trousers[341] and HIA 170 described BR 1 standing close to him and touching his behind .[342]

380 HIA 259 told the Inquiry that BR 1 tried to intimidate him into giving him oral sex[343] and HIA 41 told the Inquiry that BR 1 masturbated and raped him in the showers and that he saw him sexually abusing boys at the back of the school.[344] HIA 149 described BR 1 caning him for running away and fondling his genitals as he caned him.

381 The Order pointed out that the allegations made about BR 1 in the 1980 police investigation were about the "medical examinations" he undertook and inappropriate touching. They said that no allegations of masturbation, oral sex or anal rape were made about BR 1 until such allegations were made about him to the police when they were investigating the conduct of Father Brendan Smyth. These allegations resulted in BR 1 being arraigned on a variety of charges including aiding and abetting buggery, which was inaccurately reported in newspapers as buggery. Ultimately the police did

339 RUB 708.
340 RUB 60084.
341 RUB 580.
342 RUB 607.
343 RUB 683.
344 RUB 504.

not progress the charges in the Bill of Indictment against BR 1; a related civil action against the Order was discontinued. The Order has suggested that the misleading reports in the media that BR 1 had been charged with buggery led to some people, including witnesses to this Inquiry, coming forward with new allegations of more serious sexual abuse by BR 1 than they had previously made.[345]

382 A feature of the allegations against BR 1 was that he observed and touched boys when they were showering. A number of witnesses told the Inquiry about brothers observing boys in the shower and appearing to get sexual gratification from doing so (HIA 390 and HIA 388). The Order has stated that brothers had to supervise boys in the showers to prevent horseplay that could lead to accidents and while we accept that such supervision may have been necessary we consider that the discomfort witnesses remembered and described was genuine and justified.

383 We are satisfied from the evidence we have received that BR 1 used the pretence of medical examinations to sexually abuse boys and that more generally he inappropriately fondled boys. We consider it particularly significant that he acted in this way while he was the Brother Director, given the authority that role gave him and that it meant there was no brother senior to him in Rubane to whom the boys could have expressed their concerns about his behaviour. The Order has accepted in its closing submission to this module that BR 1 conducted medical examinations and put his arms around boys and touched them inappropriately and that this behaviour was "inappropriate, constituted an assault, made the boys feel uncomfortable and was abusive".[346]

Fr Brendan Smyth

384 Two witnesses in Module 3 told the Inquiry that Fr Brendan Smyth sexually abused them in Rubane (HIA 41 and DL 40.) We are dealing with allegations against Fr Smyth in Chapter 10 of this report. However, we note here that DL 40 told the Inquiry that he told BR 1 that Fr Smyth was abusing him and although he did not know what action, if any, BR 1 took, from that point on Father Smyth stopped contacting and visiting him. We have seen no evidence to suggest that BR 1 reported this abuse to the police, the Diocese or Fr Smyth's Order.

345 RUB 5969/5970.
346 RUB 9188

385 Two social workers from the EHSSB sat in on the police interviews with the residents and former residents from Rubane and provided a report about them to their senior manager, DL 524. In the report they recommended:

> "Following the investigation we both consider that all the social work staff involved with Kircubbin be made aware of the police action as soon as is practicably possible to minimise potential problems in a very delicate situation."[347]

It would appear from the evidence of DL 503 that this did not happen. DL 524 told us that he acted on the basis of his understanding that since the matter was subject to a criminal investigation with potential prosecutions to follow, he was under a duty to maintain confidentiality so as not to risk prejudicing the police investigation. He explained that he shared information about the police investigations with senior colleagues in EHSSB and that although his direct involvement was limited to the time of the initial police investigation he would have no doubt that social work staff would have been made aware of the situation once it was possible and appropriate to do so. While we accepted DL 524's explanation about his concern not to prejudice the police investigation we considered it would have been preferable to have entrusted social workers responsible for boys in Rubane and for placing boys in the home with the information on the basis of strictest confidentiality. The HSCB accepted in its closing submission to this module that social workers were not informed at the time and that that was a potential failing. **We agree and consider this failure to communicate such significant information about matters relevant to the protection and safety of children amounts to a systemic failing.**

Allegations of sexual abuse by lay staff

386 During the police investigation of BR 1 allegations emerged about a member of lay staff, DL 509, who was subsequently sentenced for three offences of indecent assault and three offences of gross indecency against two boys for which he was given a twelve-month prison sentence suspended for three years. Although the criminal proceedings related to DL 509's conduct when the two boys were in Nazareth Lodge, one of the boys, DL 56 and his older brother HIA 149, were resident in Rubane while DL 509 worked there and he was allowed to take them out on weekend trips. DL 56 is now dead but his brother HIA 149 told the Inquiry that DL

347 RUB 1666.

509 sexually abused his brother and him during one of these trips. In his evidence to the Inquiry DL 509 denied this allegation but we found HIA 149's account convincing.

387 The Inquiry heard allegations of sexual abuse against other lay members of staff and HIA 25 told us about being sexually abused when he was staying overnight in the home a man DL 417. DL 417 had taught music for a short time in Rubane and had befriended HIA 25. We will consider the case of one member of lay staff as an example of the allegations we have heard. Four witnesses HIA 19, HIA 132, HIA 56, and HIA 21 told the Inquiry they were abused by DL 134. HIA 19 described DL 134 groping him as he discussed the facts of life with him;[348] HIA 132 described being abused by DL 134 when he was alone in the car with him one evening;[349] HIA 56 described being sexually abused by DL 134, including being made to sexually engage with an older boy in the shower, who was also coerced into this activity by DL 134,[350] and HIA 21 recounted DL 134 making unsuccessful attempts to sexually abuse him, and then humiliating and abusing him by making him shower in front of him.[351]

388 HIA 21 explained that one of DL 134's attempts to abuse him was stopped by BR 13, who lived in the chalet with DL 134 and his wife DL 135, coming into DL 134's room to find out why HIA 21 had been in there for so long.[352] HIA 21 said he told BR 13 and BR 3 that something had to be done about DL 134 and DL 135[353] but did not tell them that he was being sexually abused by DL 134.

389 The Order dismissed DL 134 and his wife DL 135 and told the Inquiry that this was because of their poor relationships with the boys and other staff and that the MoHA and Bishop Philbin had become involved because DL 134 and DL 135 tried to challenge their dismissal. In 1995 former residents of Rubane were interviewed as part of Operation Overview, the investigation into physical and sexual abuse in residential homes for children in Northern Ireland. Allegations of sexual abuse by DL 134 emerged during these police investigations. The Order told the Inquiry that was the first time it was aware of any allegations about DL 134 sexually abusing boys.

348 RUB 440.
349 RUB 782-783.
350 RUB 527.
351 RUB 881-882.
352 RUB 880-881.
353 RUB 882.

390 To illustrate a changing approach to the handling of allegations of sexual abuse we will look at the case of BR 33. In August 1983 and August 1984 allegations of a sexual nature were made against BR 33, who was at that time a lay care assistant but had up until 1 August 1982 been a member of the Order. In August 1983 a resident, DL 469, and his mother made an allegation that BR 33 had put his arms around DL 469. DL 469 shortly afterwards withdrew the allegation but his social worker DL 470 undertook an investigation of it on 12 September 1983 and the Order told the Inquiry that it was recorded that DL 470 was satisfied that the allegation had been fabricated.

391 On 2 August 1984 another resident made an allegation that BR 33 fondled him as he was putting him to bed. BR 33 denied the allegations but the matter was referred to the police and Bishop Philbin as the chair of the governing board issued written instructions that BR 33 was to be suspended pending the outcome of the police investigations. During his suspension BR 33 submitted a letter of resignation, saying he wished to return to the South of Ireland and that he had permission from the police to do so. Br Martin, the then Brother Director, checked that was the case before accepting his resignation. The management committee was informed about the investigation into BR 33 and his decision to resign and Fr McCann and Br Martin met with DHSS officials in February 1985 to update them on the decision of the police to recommend no proceedings to the Director of Public Prosecutions.[354]

392 From the evidence we have heard we are satisfied that members of lay staff were engaged in sexual abuse of boys in Rubane. We are also satisfied that, as the case of BR 33 shows, by the 1980s the allegations of sexual abuse against lay staff were being reported to the appropriate authorities.

393 In addition to the allegations about sexual abuse detailed above we have heard allegations that other brothers and members of lay staff sexually abused boys in Rubane. These allegations range from touching boys outside their clothes to anal rape and include allegations that brothers acted together, combined violence with sexual abuse and used sexual abuse as a means of asserting their authority. All the relevant brothers and lay staff have denied these allegations and they and the Order have pointed out what they say are weaknesses and inconsistencies in the evidence of many of the witnesses making the allegations.

354 RUB 11101-11102.

394 We have not accepted all the allegations or all the denials we have heard. It is not the purpose of this Inquiry to make findings in relation to every allegation put to it or to set out the detail of every claim and counter claim. We have to determine whether there was sexual abuse of boys in Rubane and, if so, was it systemic? We are satisfied from the evidence we have heard that boys were sexually abused in Rubane by some brothers and some lay staff throughout the four decades the home was in operation and that this abuse was particularly prevalent up until the early 1970s. **We consider the extent and frequency of the abuse was such that it was systemic and that the understaffing and lack of oversight of the brothers' interactions with children, particularly in the evenings and at night time, enabled the conditions that allowed the abuse to occur and continue unchecked.** We found the Order failed to deal appropriately and adequately with boys who reported sexual abuse.

395 We are of the view that if the Provincial, BR 19, had involved the police in investigating the allegations about BR 17 or had even informed the governing board and/or the MoHA about the investigation there would have been the potential for not only BR 17's behaviour to be dealt with but also for the sexual abuse by BR 15 and BR 14 to be exposed. An independent and full investigation of BR 17's behaviour might have given boys more confidence to speak out about abuse, whereas the way in which the Order handled its investigation was likely to have done the opposite and reinforced for the boys that there was nothing to be gained in challenging the brothers.

396 The case of BR 14 is particularly significant because the Brother Provincial deliberately misled relevant bodies about the extent of BR 14's sexual misconduct in Rubane.

397 **We consider the Order's failings to properly investigate allegations of sexual abuse and to properly report them to relevant authorities and its failure to take proper steps to protect children from further sexual abuse amount to a systemic failure to take appropriate steps to ensure the investigation and prosecution of criminal offences involving abuse.**

398 The Order suggested that its responses to allegations of sexual abuse in 1958 and 1964 need to be understood in the context that at that time there was a lack of knowledge about the risk of adults abusing children in residential care. We accept that the sexual abuse of children

in institutional care was not well known or discussed in Northern Ireland until the 1980s when concerns emerged about Kincora. However, it is clear from the way the Order's rules were drafted that it was aware of the need to guard against intimacy between brothers and boys. For example, in relation to the conduct expected of brothers the rules state:

> "They shall not touch their pupils through playfulness or familiarity, and they shall never touch them on the face." Rule Page 103 (7)[355]

> "They shall not receive Brothers, students or outsiders in their rooms." Rule Page 13 (3*)[356]

399 The Order also went as far as to set down strict guidelines for the physical layout of buildings in order to ensure that behaviour could be observed at all times, for example how windows should be placed in doors to ensure clear sight of what was going on in rooms:

> "The Brother Director shall be careful that the parlour doors have glazed panels without curtains, in such a manner that the interior may be easily seen."[357]

We consider it reasonable to assume that it was the collective experience of the Order about the risk of sexual misbehaviour that first led to the creation and setting of these very specific rules.

400 Also, we are aware from information provided by the Order that during the six-year period that BR 19 dealt with three allegations of sexual abuse at Rubane he also dealt with similar allegations about brothers working as teachers in Southern Ireland. Therefore, we do not accept, as the Order has suggested, that he would have found it inconceivable that such abuse could occur; we are of the view that he knew only too well that it could and that in the case of Rubane he was determined to conceal the abuse from the civil and diocesan authorities.

401 We consider the failure by brothers in Rubane to adhere to the Order's rules, in particular the rules which BR 19 attempted to reinforce about not having boys in their rooms and not travelling in cars alone with boys, helped to create a climate where sexual abuse occurred on a significant scale and went unchecked. **We consider the failure by the brothers to observe their own rules was a systemic failure and that it was particularly significant because it betrayed the implicit trust that**

355 RUB 175.
356 Ibid.
357 RUB 1819.

other bodies such as the MoHA, the welfare authorities and the Diocese placed in the Order as a faith-based organisation suitable to be entrusted to run a residential home for children entrusted to their care.

402 **We consider the Order's failure to properly implement and monitor adherence to its rules, which were designed to keep boys free from sexual abuse, was a systemic failure to ensure that children were kept free from abuse.**

403 In his statement to the Inquiry, Br Pius McCarthy stated in relation to sexual abuse by brothers in Rubane:

> "There is no evidence that, at that time, the Brothers or society in general understood the harm and damage that child abuse caused and there was little understanding of the nature of a sexual predator or paedophile and how he could be effectively prevented from engaging in such behaviour."[358]

He pointed out that the dilemma of sex abuse and how to deal with it effectively was not understood by society, the Church, or the Religious Congregations.

> "It was regarded as a moral fault which could be corrected by guidance and repentance. The offender was confronted and the error of his ways pointed out to him. If he was contrite, he was advised to go to confession and make a new start in a new community."[359]

404 **We accept that until the late 1970s or early 1980s less was known and understood in Northern Ireland about the sexual abuse of children, but we consider the approach of moving brothers who had confessed to sexual abuse to other communities and not involving the police protected the position of the brother and the reputation of the Order rather than seeking to prevent further harm to children, and we consider it to be a systemic failure by the Order to ensure that children were free from abuse.**

405 We acknowledge Bishop Philbin intervened to suspend BR 1 and BR 33 but we consider that up until then there was a systemic failing in the way the Diocese responded to allegations of sexual abuse in Rubane and that its lack of action allowed the abuse to continue. The chaplains

358 RUB 173.
359 RUB 173.

in Rubane were appointed by the Diocese and were answerable to the bishop. We understand the seal of confession and that a chaplain could not tell the detail of what was said in confession to a third party. **However, we consider that the chaplains should have found a means of alerting the bishop in a more general way to concerns about sexual abuse in Rubane and that as far as we are aware this failure to do so contributed to the continuance of that abuse in Rubane. We consider this to be a systemic failure by the Diocese to ensure that children were kept free from abuse and a systemic failure to ensure the institution provided proper care.**

406 The Belfast Welfare Authority recognised the need for social workers to maintain contact with children in care and introduced a policy of monthly visits and a three monthly review form which listed the dates on which social workers visited children. Referring to this policy in his evidence to the Hughes Inquiry Mr Bunting explained that it was implemented by the Belfast Welfare Authority and then the EHSSB despite the lack of statutory compulsion for such visiting. However, he acknowledged that it was not fully implemented because of shortages of social workers and the need for some clarification between the roles of field workers and residential social workers.[360]

407 In its evidence to the Inquiry the HSCB accepted that from the evidence available insufficient emphasis was placed on regular and frequent visits by social workers to children in Rubane in the 1950s and 1960s and/or there was insufficient recording of such visits. It recognised that this lack of visiting amounted to a weakness in this aspect of social work practice at that time[361] but pointed out that it improved in the 1970s.[362] The Order confirmed that social workers visited boys during the 1970s[363] and that although the frequency of visits varied in that period the involvement of social workers, particularly in care reviews, improved dramatically post 1980.[364]

408 We accept that the arrangements established by the Belfast Welfare Authority for social workers to visit children in care were ahead of their time and were not required by statute and we recognise the severe pressures

360 RUB 9253/4.
361 RUB 9256.
362 RUB 9254-9256.
363 RUB 028.
364 RUB026.

social work departments were operating under during the height of the Troubles. However, we are of the view that more regular visits by social workers to boys they placed in Rubane in the 1950s and 1960s might have enabled boys suffering sexual abuse to disclose it.

409 That said, we consider that the EHSSB acted appropriately in reporting their concerns about Rubane to the police and to the DHSS, continuing its embargo on admissions and providing social workers to support boys while they were being interviewed by the police.

410 It became clear during the Inquiry that the case of sexual abuse by BR 14 in 1964 was not referred to the Hughes Inquiry. In October 2014, the HSCB told us that the Board did not bring this matter to the attention of the Hughes Inquiry despite Down Welfare Authority and Belfast Welfare Authority's involvement in it because records retention protocols meant that relevant records were not retained. Subsequently the HSCB informed us in September 2015 that a relevant file relating to DL 13 had been located amongst files relating to adoptions. The location of the file did not alter the fact that at the time of the Hughes Inquiry this case was not brought to the attention of senior EHSSB managers who had asked Districts to provide them with all relevant cases for the Inquiry. In seeking to address this oversight the Chief Executive of the HSCB explained that during the twenty years between the investigation of the abuse of DL 13 in Rubane and the Hughes Inquiry, the major reorganisation of local government in 1973 resulted in significant staff changes and changes in office and filing arrangements that led to a lack of corporate memory in relation to this case. We consider that there would have been more likelihood of this case being referred to the Hughes Inquiry had DL 13's records been properly filed and that this lapse in records management was poor practice. However, we accept how corporate memory about an investigation into abuse of a boy no longer in care, which could not be concluded because of the lack of co-operation of the alleged abuser, was lost in the aftermath of major organisational change.

411 The Department explained that it did not refer this matter to the Hughes Inquiry as the relevant file had been sent to the Northern Ireland Office because there was a criminal element to the case and the staff in the Department who engaged with the Hughes Inquiry were not aware of the file. Given that the Department had an ongoing responsibility for the regulation of Rubane we consider it should have retained some record of the alleged abuse and the assurances received from the De La Salle Order

in relation to it. **We consider the Department's failure to maintain intelligence about an investigation into sexual abuse in a children's home in a manner that allowed its existence to be known to relevant staff to be a systemic failure to take all proper steps to prevent, detect and disclose abuse as it meant the Hughes Inquiry was not made aware of the full extent of sexual abuse in Rubane.**

Peer sexual abuse

412 Peer sexual activity among adolescent boys in a predominately male residential setting is not uncommon and a number of witnesses, for example, HIA 21, HIA 56, HIA 16 and HIA 225 referred to consensual sexual exploration that was part of growing up. However, the Inquiry heard evidence of non-consensual sexual activity among boys, including occasions of attempted rape, rape and group rape.

413 HIA 225 acknowledged sexual activity between boys and how "it was hard to work out what was right and what was wrong" but he differentiated that behaviour from the attempted rape of him by two older boys, whom he described as being in an open sexual relationship with each other. He described how, days after the attempted rape, the two boys involved were beating him up and BR 2 came across this and caned all three boys for fighting. He explained that he did not tell BR 2 about the abuse or report it to any other member of staff because he was frightened, since one of the boys who had abused him, DL 95, was the best fighter in the school.[365]

414 HIA 21 accepted in his evidence that he was involved in sexual exploration with other boys[366] but told the Inquiry he was raped by HIA 147 and another boy in a derelict building outside the grounds of Rubane.[367] A number of witnesses made allegations about HIA 147, (for example, HIA 19)[368] and we noted that while HIA 147 was being sexually predatory towards other boys he was being sexually abused by BR 15.

415 HIA 64 described having to fight off bigger boys who tried to sexually abuse him[369] and HIA 152 described having to regularly perform oral sex on older boys because if he refused they would beat him.[370] HIA 222 also referred to his fear of older boys and although he was not sexually abused himself

365 RUB 642.
366 RUB 881.
367 RUB 883.
368 RUB 441.
369 RUB 547.
370 RUB 603.

he described coming across a group of older boys raping a younger boy in the woods and walking by and not intervening for fear that the same thing would happen to him.[371] In contrast, HIA 225 told the Inquiry how he repelled the sexual advances of HIA 21 and was able to do so because he was not frightened of him.[372]

416 It was clear from the evidence we heard that brothers were aware of the sexual activity amongst the boys. HIA 21, who described being sexually abused by HIA 147, said he was 90% certain that he had told BR 6 about the abuse. HIA 152 recalled brothers on occasion telling him to let them know if certain other boys touched him. He said he told BR 3 about being sexually abused by older boys but he did nothing about it.[373]

417 In contrast, HIA 56 described BR 3 giving him a severe beating because he suspected HIA 56 was sexually interfering with a new boy. He recalled BR 3 saying: "he's only in the place and you're at him".[374]

418 HIA 259 told the Inquiry he was sexually abused by an older boy, DL 58, who also physically abused him and took his pocket money. He said the brothers and staff knew about boys sexually abusing other boys but closed their ears to it:

> "If you reported it you would have got a clip on the ear or a more severe punishment. There was a culture of silence in the home in relation to sexual abuse."[375]

419 HIA 259 also said that BR 10 caught him and other boys beating up a boy to stop him sexually abusing a younger boy and when they explained why they had hit the boy BR 10 responded, "This is a boy's home what do you expect?" and proceeded to punish them for fighting but did not punish the boy they had hit.[376] When questioned about this at the Inquiry BR 10 said he had no memory of the incident but that if he had made such a comment he would have been referring to expecting fighting amongst boys.[377]

420 The police investigation in Rubane following the allegations about BR 1 identified non-consensual sexual activity amongst the boys. The police considered that there was sufficient evidence to convict the boys involved

371 RUB 631.
372 RUB 603.
373 RUB 603.
374 RUB 529.
375 RUB 681-682.
376 RUB 684-685.
377 pp.102/3, Day 72, 25 November 2014.

but decided not to because they were of similar ages. The Order told the Inquiry that the brothers were not informed by the police or social services about these police findings about sexual activity between boys. However, Bob Bunting told the Inquiry that the report prepared by the two EHSSB social workers who sat in on the interviews was shared with the management committee of Rubane and he thought it was also shared with Bishop Philbin.[378]

421 BR 2 confirmed that the brothers were aware of the risk of peer sexual activity and that they moved some boys from the chalets to the main house to keep a closer eye on them, limited access to the woods and sent some boys to see psychiatrists.[379] However, the Order accepted that with the benefit of hindsight consensual sexual activity and peer abuse among the boys was a greater problem than they appreciated contemporaneously.[380]

422 Although sexual exploration can be expected and is a normal part of growing up we are convinced from the evidence we heard that some of the sexual activity between boys in Rubane extended to sexual abuse on the grounds that it was not consensual, involved physical force or was inflicted by one or more older boys on a younger boy. We noted that some boys who were identified as being responsible for such behaviour gave convincing accounts of how they were sexually abused as young children prior to arriving in Rubane. While we are not suggesting that there is necessarily a correlation between being sexually abused and then going on to become sexually abusive, it does appear that some boys in Rubane modelled their behaviour on the way they were treated and became abusive once they grew into positions of power over younger boys. It also appears that there was a bullying, and at times violent, aspect to the peer sexual abuse in Rubane and we consider this reflects the more general culture in Rubane of bullying and the use of superior physical power to gain and maintain domination.

423 We consider that the brothers did identify and attempt to stop peer sexual abuse, particularly in the 1970s, and we do not therefore consider their inability to eradicate it to be a systemic failing.

378 Day 76, p.132.
379 RUB 1080-1082.
380 RUB 323.

Emotional abuse

424 There was clearly very significant emotional abuse associated with the physical and sexual abuse that boys suffered in Rubane. Witnesses talked of the fear and trepidation they experienced not knowing when they would next be subject to abuse, the confusion that grooming behaviour caused them and the mental impact of sexual and physical abuse. They told us that the brothers' inconsistent behaviour and changeable moods meant they felt they had to be constantly on their guard.

425 We consider the fear and intimidation created by the combination of sexual and physical abuse by some brothers, some of whom were abusing boys at the same time, was so corrosive to the childhoods of the boys who suffered this abuse and to the boys who lived in the shadow of it that it constituted emotional abuse.

426 Witnesses told us about how the abuse they suffered in Rubane affected them throughout their lives and caused them difficulties in establishing and maintaining personal relationships and in parenting. Some witnesses told us about the struggles they have had with alcohol and drug dependency and mental illness, and many referred to men who had been boys with them in Rubane who had died early deaths, some at their own hands, or who were too unwell or vulnerable to engage with the Inquiry. The impact of this emotional abuse has remained with witnesses throughout their lives. This was well illustrated by the testimony of HIA 56:

> "I have gone through life feeling sad and empty. I feel drained. I feel I have no worth, no value. I am lonely. I feel excluded and isolated. I wonder why I am different. I question 'is there something wrong with me?' I am clamped to the past. I have no qualifications, no employment prospects. I feel completely and utterly contaminated by abuse. I am sexually disorientated. I have prostituted my body and my mind - I feel destroyed and worthless. I avoid people where possible. I always try to please and pretend there is nothing wrong. I can't take the risk of letting people get too close. I feel afraid to trust. I am aware of the loneliness and isolation this creates. It is despairing but I feel safer. I have no motivation to make progress in anything. I have never loved or been loved. Simmering beneath the surface I feel dangerously full of unexpressed rage and anger with a dreadful sense of hopelessness."[381]

381 RUB 532.

427 Only a few witnesses spoke of emotional abuse that was separate from that associated with sexual or physical abuse. HIA 385 and HIA 388 described the fear and distress they suffered when BR 15 threw them into the swimming pool even though they could not swim[382] and HIA 261 described observing BR 15 treating a boy aged around 8, and small for his age, in the same way.[383] HIA 244 described BR 15 making older boys throw new boys repeatedly into the swimming pool whether they could swim or not.[384]

428 HIA 19 and HIA 50 said DL 6 called them names and humiliated them.[385] HIA 382 who was generally very positive about his time at Rubane recalled a member of staff telling boys they were a "waste of space" and "useless".[386]

429 **We consider the fear and distress caused to some boys in Rubane as a result of the physical and/or sexual abuse they suffered or witnessed others suffering amounts to a systemic failure by the Order to keep the boys free from harm.**

Neglect

Medical treatment

430 Six witnesses complained about inadequate medical treatment in Rubane and some of them said they never saw a doctor or dentist while they were in the home,[387] HIA 31 said there was a delay in him being taken to the hospital after he was stabbed in the back by another boy.[388]

431 More witnesses remembered receiving medical treatment from a local doctor, being brought to see a visiting dentist and receiving hospital treatment for illnesses and injuries.

Food

432 Some witnesses[389] said the food in Rubane was basic but all right and HIA 45 said it was better than he would have got outside, but other witnesses complained about poor quality and insufficient food.[390]

382 RUB 734, RUB 842.
383 RUB 701.
384 RUB 653.
385 RUB 442, RUB 767.
386 RUB 728.
387 HIA 252, HIA 97, HIA 390, HAI 388, HIA 385 and HIA 259.
388 Day 66, p.87.
389 HIA 36, HIA 25 and HIA 359.
390 HIA 385, 244, 97, 183, 247, and 262.

HIA 385 stated, "It was the same food every day, and we were never given enough. We were always hungry"[391] and HIA 16 remembered having to compete with other boys for food, '...all the boys would grab the bread because they were so hungry and you had to be quick or you didn't get any."[392] HIA 262 recalled "We were always hungry. If we weren't fit enough or fast enough when we were brought in for breakfast or our evening meal, it was gone. If I didn't dive for food then I went hungry."[393] A few witnesses expressed the view that the brothers, who ate separately from the boys, got better food;[394] the Order denied that was the case.

433 In the main, witnesses appeared to find the food adequate and we accept that particularly in the early years the Order had to feed hungry adolescent boys with limited resources. We consider that on the whole the boys were adequately fed and were not neglected in this respect.

434 **However, as stated previously, we consider the cramped, overcrowded sleeping and bathing facilities in Rubane before the chalets were built in 1968/1969 constitute neglect and, as we have stated previously, the length of time the Diocese, the Order and the MoHA allowed them to continue amounts to a systemic failing on all their parts to provide proper care.**

Unacceptable practices

Mixture of boys in Rubane

435 A number of witnesses talked about the implications of Rubane accommodating a mixture of boys from Nazareth Lodge, many of whom were in care from infanthood and used to a disciplined institutional life, and boys who had been admitted directly from the community mainly because of failure to attend school and/or involvement in petty crime. The behaviour of these boys in the community was such that they were deemed to be beyond the control of their parents and in some cases beyond the control of the other children's homes. DL 455 commented on this mix:

> "On reflection, this was the biggest problem:- streetwise sexualised boys being placed into care with vulnerable sheltered children."[395]

391 RUB 733.
392 RUB 419.
393 RUB 830.
394 HIA 261 and HIA 262.
395 RUB 1492.

HIA 97 commented:

> "I assumed we were all orphans or children from single parent families like myself but they would send lads that were due for release from the borstal in Milltown down to Kircubbin and they mixed them all in with us. It was horrific really."[396]

436 BR 2 commented on the mix of boys in his statement:

> "...ironically, the very issue that had driven Br Stephen Kelly in the conception of Rubane the prevention of 'mixing' the 'orphans and criminals' slowly developed in Rubane."[397]

437 We think it is important to recognise in this regard that some of the boys who transferred from Nazareth Lodge to Rubane had experienced physical and sexual abuse in that home and they demonstrated the effects of that abuse in their behaviour. They may have been more used to and acquiescent to the routine and discipline of institutional life but many were troubled children. Equally, some boys coming directly from the community were dealing with the trauma of being received into care for the first time and were vulnerable and distressed about leaving their families and their homes.

438 BR 2 described Rubane becoming a "catch all institution".[398] While not wishing to underestimate the expectations that would have been on the Order to admit boys, particularly in emergency situations, and the financial and other pressures to increase and maintain numbers in Rubane, this seems to suggest a somewhat passive approach to admissions. We consider that the Order, under the governance of the governing board, had a responsibility to manage admissions and to manage the mix of children that it accepted into its care.

Lack of background information about boys admitted to Rubane

439 BR 2 pointed out that often only the "bare bones" of information would transfer with a child coming to Rubane and that:

> "Lack of information ensured that empathy with a new entrant could not be optimised and also meant that the needs and problems of individual boys were not properly assessed or identified at admission. Important aspects of a boy's background were not necessarily passed on."[399]

396 RUB 568.
397 RUB 1041.
398 RUB 1066.
399 RUB 1055.

He explained that this was a particular issue for boys admitted from Nazareth Lodge and that the information received about them was sparse in the extreme:

> "...without names of parent/siblings, where they came from, their medical history, their educational attainments or special needs."[400]

We consider the Sisters of Nazareth's failure to pass relevant information about a child's time in Nazareth Lodge, even if little was known about their lives before coming into care, and the Order's willingness to accept children with this paucity of background information was unacceptable. **We consider these practices showed a lack of care and consideration for each child's individuality, development and well being and that they amount to a systemic failure by the Sisters of Nazareth and the Order to ensure the provision of proper care.**

Boxing

440 Some witnesses recalled boxing matches being used by the brothers as a controlled way of allowing boys to settle disputes while others, such as HIA 244 and HIA 24, told us brothers made them fight older boys and did not intervene when they were being badly hurt in unequal matches.[401] For example, HIA 97 described BR 15 making him fight with older boys:

> "he would make us box the bigger boys and let them knock the hell out of us. I was younger and smaller than most of the boys and I think it amused him to see me getting hit by the bigger boys."[402]

441 Although we recognise that boxing as a sport can teach boys self discipline and how to control aggression, we accept that some children were made to engage in boxing matches against older boys and that some were hurt in these matches. We also consider that the use of boxing matches to settle disputes reinforced the general culture in Rubane of dominance being achieved through superior physical force rather than offering the boys other ways and methods for resolving their differences.

Soccer

442 HIA 97 and HIA 390 described being hit for playing soccer as it was an English game. The Order conceded that boys would not have been allowed

400 RUB 1040
401 RUB 650 and RUB 452.
402 RUB 572.

to play soccer in the 1950s and early 1960s but that from then on soccer would have been allowed.

Potato-picking

443 Some witnesses talked positively of potato picking; HIA 64 said

> "We used to go potato–picking on the farm at Rubane and for outside farmers. It was tough work but I enjoyed it. I don't know if the farmers paid the Brothers but our payment was a trip to Belfast to the pictures once a year as a treat."[403]

Other witnesses remember being paid either daily or weekly for doing this work, DL 244 commented:

> "I remember going potato-picking on local farms in October. I got 2/6 each night. I really enjoyed it, we got out to local farms, got stew for lunch and had a good time."[404]

444 In contrast, HIA 244 described being "dragged out of school"[405] to go potato-picking for local farmers and he suggested that while the brothers got paid £1 per boy for a week's work the boys only received a shilling a week from that money.[406] However, he also remembered the brothers asking the boys how the money from the potato-picking should be spent. He recalled the boys suggested a roof should be added to the swimming pool but that instead new musical instruments were purchased for the band.[407] This suggests the work was lucrative and that the brothers used the earnings for the benefit of the boys.

445 Eight witnesses complained about having to work in neighbouring farms and said that the work went beyond potato-picking to hard physical labour. HIA 26 told us:

> "We were hired out to farmers. I worked on these farms from I entered the home at nine years old until I left Rubane house. I thought it was child labour. We had to pile up large bales of hay in the fields throughout the summer. We would work the entire day."[408]

403 RUB 548.
404 RUB 1486.
405 RUB 652.
406 Ibid.
407 RUB 653.
408 RUB 457.

HIA 244 recounted having to continue to pick potatoes in very cold conditions until his hands were, "cold, red raw cut and bleeding".[409] HIA 385 said he got no treatment when he put a pitch fork through his foot when he was picking potatoes because his hands were so cold[410] and HIA 252 recounted not being properly clothed for the work and not being allowed a shower to clean up after doing it.[411]

446 These witnesses were all admitted to Rubane in the 1950s and 1960s which suggests this heavier labour may only have applied in these years. As we have already pointed out when considering similar complaints made about the Sisters of Nazareth home at Termonbacca, before the advent of potato-picking machines it was very common in farming families at that time for children to help with potato-picking. **We consider expecting the boys to help with potato-picking on the farm in Rubane was reasonable but that hiring them out to pick potatoes and undertake other types of labour in neighbouring farms and requiring them to do this work in adverse weather and with inadequate clothing was inappropriate and amounts to a systemic failing to provide proper care.**

Clothing

447 As previously referred to in 1962, MoHA inspectors, Ms Forrest and Ms Hill, reported that although all the boys in Rubane appeared in good health:

> "…many looked pinched and cold; their clothing in many instances was in very bad order, threadbare and torn, and affording little protection against the weather."[412]

448 We noted that as late as the mid-1970s and early 1980s social workers were expressing concerns about the appearance of boys in Rubane and their ill-fitting clothes. In her evidence to the Inquiry, DL 517 described a boy being admitted to Rubane in 1980 and being given a pair of trousers from a general store:

> "…which were so wide he needed a belt to hold them up and they were too short for him, although he was relatively small in stature. I was told he would have to wear them and that he may eventually get trousers which fitted him if they came into the store."[413]

409 RUB 652.
410 RUB 734.
411 RUB 666.
412 RUB 11869.
413 RUB 1687.

Referring to the same period, another social worker, DL 516, told the Inquiry that the boys in Rubane "presented like 'orphans' and clothing did not take consideration of their personality or size". The Order did not accept that boys presented as orphans. It accepted that because of resource difficulties there may have been isolated occurrences during this period of boys being dressed inappropriately but pointed to the photographs it supplied to the Inquiry which showed boys from the mid 1970s onwards in a variety of attire in accordance with the style of the era. However, the bulk buying of clothing and distribution of it from a central store did not cease in Rubane until 1981. In the report of the SWAG inspection carried out in March 1981, inspectors noted that from the start of 1981 boys were allowed to purchase their own clothing in shops of their choosing and pay for it with cash. This indicates that the adequacy and suitability of clothing for some children in Rubane continued to be an issue as late as 1980. **We consider it a systemic failing that the Order did not ensure initially that all boys in Rubane were adequately clothed and in later years up to 1981 failed to ensure that all boys were appropriately clothed.**

Visits to families

449 Where boys had families to whom they could return, arrangements were at times made for them to return home for weekends, or for longer holidays in the summer. For example, HIA 19 stayed with his grandparents for nine weeks one summer.[414] Where boys had no family with whom they could stay, arrangements were sometimes made with families to take them for occasional weekends or for longer periods in the summer.

450 In the main, these opportunities were valued and enjoyed and we heard from witnesses who have maintained contact with families that they were sent to. However, some witnesses complained of having to undertake excessive chores when on placements with families. (e.g. HIA 259)[415] It is not clear how these families were recruited and although BR 2 refers in correspondence in 1973 to the welfare authorities making "a routine visit" to families willing to have boys to stay over the Christmas period[416] it is not clear to what extent vetting of families was carried out in the early days.

414 RUB 441.
415 RUB 685.
416 RUB 1097.

Chores

451 Witnesses described having to do daily chores, such as cleaning toilets, sweeping, scrubbing and polishing floors and more extensive cleaning of, for example, the stairwells at the weekend. Although some witnesses complained about having to do chores, we did not get the impression that they were excessive.

Shaving of Heads

452 The Order explained that head shaving was used as a means of controlling the spread of head lice and in the main witnesses referred to it in that way. However, four witnesses referred to having their heads shaved as a punishment.[417]

Treatment of enuresis

453 As the boys in Rubane were older we heard fewer complaints about how enuresis was dealt with than was the case in homes for younger children. However, HIA 97 said he was hit for wetting the bed[418] and HIA 219 said he was made to take cold showers as punishment for wetting the bed.[419] HIA 50 told us that BR 33 threatened to tell the other boys that HIA 50 wet the bed,[420] HIA 385 described boys lying in wet bed clothes for fear of being punished for wetting their beds[421] and HIA 262 described boys being humiliated for bed wetting.[422]

454 HIA 262 and HIA 16 remembered a "wet house" for boys who wet the bed;[423] such segregation of boys who wet their beds from other boys was against the guidance provided about dealing with enuresis in the memorandum by the Home Office on the Conduct of Children's Homes, which was issued in 1952.[424] However there was evidence that the Order attempted to assist boys who suffered from enuresis: BR 2 explained that medical advice was sought and alarm blankets were used to wake the boys.[425] Witnesses told us of a system where boys were paid an allowance

417 HIA 45, 59, 97 and 244.
418 RUB 570.
419 RUB 809.
420 RUB 766.
421 RUB 732-733.
422 RUB 829.
423 RUB 829 and RUB 419.
424 SND15700.
425 RUB 1056.

to set an alarm clock and wake a number of times during the night to get boys who were in danger of wetting their bed up to go to the toilet.

455 While not discounting the negative experiences of some witnesses it would seem in general that bed-wetting was dealt with in a tolerant manner.

Preparation for leaving care

456 A number of witnesses told the Inquiry about the lack of preparation they received for life after care and how unprepared they were for life outside.[426]

457 HIA 262 stated:

> "There was no preparation for going out into the world. ...One minute I was in Rubane and the next minute I was in Belfast. They would put us into lodgings and boarding houses, and get us a job. The jobs were always menial because we had no education. We had no experience of handling money or even communicating with people."[427]

458 HIA 279 recounted that on the day he was leaving:

> "Someone came into the room at that time and I recall them saying, 'Your two brothers have been picked to go to Australia so you might as well go too'. ... That was the only discussion anyone in the home ever had with me regarding going to Australia. No-one ever asked me if I wanted to go, and the day I left Rubane was the first day I realised that I was going to Australia."[428]

459 Witnesses talked about the suddenness of their departure. HIA 132 said he was given an hour to pack[429]:

> "I was given no preparation for life after care. We were never taught the value of money or how to manage our money. We were never taught social skills or how to look after ourselves. We were just left on our own to get on with it."[430]

460 HIA 183 told the Inquiry:

> "I remember leaving Rubane and walking down the road to get the bus to go to my first job. I had a suitcase with two of everything, two pairs of pants, two pairs of socks and one suit. It was the loneliest day of my

426 HIA 110 (RUB 591) and HIA 16 (RUB 422).
427 RUB 835.
428 RUB 900.
429 RUB 783.
430 RUB 784.

life. I had no-one. I had no education and I was worried about how I was going to cope with the outside world.".[431]

461 HIA 25 commented:

> "When I left the care system I was completely unprepared for life. Apart from two weeks in a flat on your own in the grounds of Rubane, there was no preparation. One day they said, 'You're out' and the next I was gone."[432]

462 In later years the Order did try in a limited way to prepare boys for leaving care by giving them the experience of being self-sufficient for a two-week period in one of the chalets. Also, in 1980 the Order agreed that social worker DL 517, and a colleague could work with a group of boys in Rubane to help them prepare for leaving care.

463 The Order, the governing board and the management committee recognised that lack of aftercare was a problem and became particularly concerned when a number of ex-residents got caught up in the civil unrest and some were murdered. HIA 56 referred to the additional challenges the Troubles caused for boys leaving Rubane:

> "They put us in the Falls Road and we didn't even know what Protestants were. They should have prepared us for going out into the world. We were put into the middle of a war and we didn't even know what was going on."[433]

He also recalled sensing that BR 2 was reluctant to leave him and another boy at the lodgings: "he stayed for ages and he gave us two pounds each."[434]

464 The Order explained it engaged with the Nazareth Lodge welfare committee, which was established to support former residents of Nazareth Lodge to obtain accommodation and employment when they left care, and that it linked with a welfare officer, Mr Murphy, and in time his successor, Mr Digney, who had been employed by the committee to undertake this work. In the 1970s a half-way house and youth club, St Augustine's, was set up principally to support former residents of Nazareth Lodge and Rubane. These facilities were seen as particularly essential for boys leaving Rubane who had previously been in Nazareth Lodge because, as BR 2 explained in

431 RUB 619
432 RUB 856
433 RUB 530
434 Ibid.

his statement, they had few relationships outside Rubane and lacked the social network supports that families could provide.

465 **We consider the lack of preparation for leaving care, suddenness of departure from the home and absence of aftercare for boys in the initial years in Rubane amount to a systemic failing by the Diocese and the Order to ensure the home provided proper care.** However, we equally recognise that when the Order and the Diocese became increasingly concerned about the lack of aftercare and the risks that created for boys particularly during the Troubles, it made considerable efforts to provide this aspect of continuing care.

Apologies

466 Before setting out our conclusions about Rubane we consider it appropriate to first acknowledge and record the apologies the Order and the Diocese made to former residents of Rubane at part of this Inquiry. At the opening of the Inquiry, the Order made the following apology:

> "First and foremost, the Brothers would wish to say publicly at the outset of this Inquiry that they accept and deeply regret that boys in their care were abused. They wish to offer their sincere and unreserved apology to all those whom they failed to protect. The De La Salle Order has previously acknowledged that innocent victims within its care were abused by some of its members. That some Brothers abused boys in their care was in total contradiction of their vocations as De La Salle Brothers and of their mission as established by their founder, namely to look after the welfare and educational needs of deprived, vulnerable and abandoned children. The Brothers recognise the immense pain and suffering and damage caused to those victims who have been abused. The Brothers recognise the sense of betrayal that the victims have experienced and the violation of trust caused by certain Brothers within the order. They recognise that there have been failures to protect the victims. The De La Salle Order deeply regrets the acts of some of its members which have irreparably damaged the reputation of the Order and undermined the selfless care provided by so many of the Brothers in pursuance of their vocation."

467 The Diocese also expressed its deep sorrow and regret that any child was abused while a resident in Rubane in the statement made on its behalf by Fr Timothy Bartlett:

> "In conclusion, the Diocese wishes to express its deep sorrow and regret that any child was abused while a resident in Rubane House.

> Established with the sole intention of improving the circumstances and opportunities of the children in its care, Rubane House, as with any institution founded on Christian principles, should have been exemplary in the love, dignity and protection it provided. Clearly, for too many, and despite the best efforts of many of the staff, this was far from the case. It is our hope that this Inquiry will go some way to helping those who experienced such abuse to have their voices heard and their painful experiences acknowledged and they will be assisted in advancing towards healing."[435]

Father Bartlett also stated when he gave oral evidence to the Inquiry about Rubane:

> "...I find it quite shocking even at a distance and even having some sense of the culture of the time, both within society and within the church, that the safety of children was not the first priority in everything. In fact it didn't seem to appear anywhere in the priorities of either the Management Board or the Governing Board or the general practice of how the home was run."[436]

Conclusions

468 In the different sections of this chapter we have set out our conclusions about systemic failings to ensure:

- Rubane provided proper care;
- Children in Rubane would be free from abuse;
- All proper steps were taken to prevent, detect and disclose abuse in Rubane; and,
- Appropriate steps were taken to ensure the investigation and prosecution of criminal offences involving abuse in Rubane.

469 We conclude by setting out below the individual and in some instances shared responsibility that the Northern Ireland Government as represented by the MoHA and its successor Departments, the Diocese, the Order and the Welfare Authorities and their successor bodies must carry for these systemic failings.

435 RUB 5324.
436 Day 78, 11 December 2014, pp.9-10.

We are satisfied that:

The Ministry of Home Affairs:

(a) failed to insist from the outset that Rubane be developed on the smaller children's home model in line with government policy;

(b) contributed to a systemic failure to ensure Rubane provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to continue for a decade while over-crowding increased and the facilities and staffing levels became more inadequate and unsatisfactory;

(c) failed as the registering body to clarify with the Diocese and the Order the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care;

(d) failed to ensure Rubane provided proper care by allowing the number of boys accommodated to more than double from 30 to 71 within six years without requiring the necessary improvements to the facilities or increases in staffing levels;

(e) failed to seek confirmation of who was the administering authority for Rubane and failed to check that monthly visiting was happening and thereby allowed crucial aspects of the statutory framework designed to promote and protect the welfare of children in voluntary homes to be ignored by the Diocese and the Order.

The Northern Ireland Government, as represented by the DHSS:

(a) failed to inspect the standard of care being provided in Rubane between 1976 and 1981;

(b) failed to ensure that the inspections of Rubane that were carried out in the 1970s gained a genuine insight into the quality of care being provided;

(c) failed to properly respond to the concerns raised by the EHSSB in 1981 about the general care provided to all boys in Rubane and thereby failed to acknowledge and exercise its statutory authority and powers as the registration and inspection body for Rubane; and,

(d) failed to maintain information about an investigation into sexual abuse in a children's home in a manner that allowed its existence to be known to relevant staff and thereby shared with the Hughes Inquiry.

The Diocese:

(a) contributed to a systemic failure to ensure Rubane provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to continue for a decade while over-crowding increased and the facilities and staffing levels became more inadequate and unsatisfactory;

(b) failed to clarify with the Order and the MoHA as the registering body the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care;

(c) failed to meet statutory regulations for voluntary children's home, in particular, failed to confirm the administering authority for Rubane and to appoint a monthly visitor;

(d) failed to take responsibility for negotiations with the MoHA about the development of the home and by only holding annual meetings of the governing board during the Order's negotiations with the MoHA caused delay and late interventions in planning;

(e) failed to hold meetings of the governing board between 1968 and 1972 and between 1982 and 1985 and thereby to assure itself of the quality of care being provided in Rubane;

(f) failed, through the chaplains appointed to Rubane, to find a means that respected the seal of confession but enabled information provided by boys about the physical and sexual abuse they were suffering to be shared with the relevant bishop and acted upon; and

(g) failed through Father McCann's response to the first assault by BR 77 to take all proper steps to prevent, detect and disclose abuse.

The De La Salle Order:

(a) contributed to a systemic failure to ensure Rubane provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to

continue for a decade while over-crowding increased and the facilities and staffing levels became more inadequate and unsatisfactory;

(b) failed to clarify with the Diocese and the MoHA as the registering body the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care;

(c) failed to meet statutory regulations for voluntary children's home, in particular, failed to confirm the administering authority for Rubane and to appoint a monthly visitor;

(d) failed to prevent excessive physical punishment by some brothers and lay staff;

(e) failed to prevent random violence by some brothers and lay staff which in some cases amounted to serious physical assault;

(f) failed to ensure that corporal punishment was administered in line with statutory regulations and the Order's own rules;

(g) failed to accurately record and report the use of corporal punishment as required by statutory regulations;

(h) failed to deal adequately with incidents of physical violence by brothers and lay staff towards boys which were brought to the attention of Brother Directors;

(i) failed to take necessary action to enable the investigation and prosecution of criminal offences involving physical abuse;

(j) failed to inform the Department or the Health and Social Services Boards about the search of Rubane and the reasons for it and therefore did not work with them to identify and manage any continuing risk to the welfare and safety of the boys in Rubane at that time;

(k) failed to report serious assaults by BR 77 to the police in order to protect the brother and the reputation of the Order rather than protect vulnerable children;

(l) failed to curtail BR 77's contact with children while he was subject to police investigations about physical assaults of boys in Rubane and instead moved him to work in a school;

(m) failed to provide guidance and effective supervision to brothers and to ensure particularly in the earlier years that they had a

reasonable workload that avoided excessive contact time with the boys;

(n) failed to provide guidance and effective supervision to lay staff in Rubane, particularly to those who were clearly having difficulties in meeting the challenges of working with adolescent boys;

(o) failed to address understaffing, thereby allowing a lack of oversight of the brothers' interactions with boys, particularly in the evenings and at night time, that enabled sexual abuse to occur and continue unchecked;

(p) failed to properly investigate allegations of sexual abuse;

(q) failed to take necessary action to enable the investigation and prosecution of criminal offences involving sexual abuse;

(r) failed to report its investigation of the allegations of sexual abuse against BR 17 to the governing board, the MoHA or the police;

(s) failed to be truthful about the extent of BR 14's sexual abuse of boys and deliberately misled the MoHA about it;

(t) failed to report its investigation of the allegations of sexual abuse by HIA 36 against BR 15 to the governing board, the MoHA or the police;

(u) failed to implement and monitor adherence to its rules about how brothers should manage their interactions with boys and thereby betrayed the implicit trust that other bodies such as the MoHA, the welfare authorities and the Diocese placed in the Order as a faith-based organisation suitable to be entrusted to run a residential home for children;

(v) failed to curtail the activities of BR 17 or increase monitoring of him despite suspicions that he sexually abused boys in Rubane and then moved him to a school where he would have continued trusted access to children which he ultimately abused;

(w) failed to report brothers who admitted sexual abuse of children to the police and thereby protected the position of such brothers and the reputation of the Order rather than seeking to prevent further harm to children;

(x) failed to keep boys free from the pain, fear and distress caused by the physical and/or sexual abuse they suffered or witnessed others suffering in Rubane;

(y) failed to limit the boys' help with potato-picking to the farm in Rubane and instead required them to pick potatoes and undertake other types of labour in neighbouring farms in adverse weather and with inappropriate clothing;

(z) failed to ensure initially that all boys in Rubane were adequately clothed and in later years up to 1981 failed to ensure that all boys were appropriately clothed; and

(aa) failed to require the Sisters of Nazareth to provide relevant information about at least a child's time in Nazareth Lodge when they were being transferred to Rubane and thereby demonstrated a lack of care and consideration for each child's individuality, development and well being.

The Welfare Authorities:

(a) failed in the period prior to the opening of chalets in 1968 to address the fact that the home they were placing boys in had inadequate facilities and was poorly staffed;

(b) the EHSSB failed to alert social workers to the police investigations in 1980 into physical and sexual abuse in Rubane.

Chapter 12:

Module 7 – St Patrick's Training School

The Module

1 The seventh Module concerned four training schools, the first being St Patrick's, a Roman Catholic school run by the De La Salle Order. The Module commenced on 1 September 2015, Day 134 of the Inquiry, with a general introduction to the training school system by Senior Counsel, followed by an address by Junior Counsel concerning St Patrick's, and it ended on 14 October 2015, Day 150.

2 A total of 27 applicants provided statements which related to St Patrick's. Of these, eleven were read out for various reasons. Two had sadly died, some had given evidence in a previous module about another home, so their observations on St Patrick's had been provided earlier, and some were unwell. One witness who had provided a statement decided not to give oral evidence after consultation with counsel on the day. Four former residents at St Patrick's also gave evidence, while not being applicants. In all, we therefore received oral evidence during the Module from 19 witnesses who had been resident in the training school. A further 39 former residents had given information to the police about allegations or had made civil claims, so that evidence was considered from a total of 70 people who had attended St Patrick's.

3 Seven brothers and seven other members of staff gave oral evidence. One witness who had inspected St Patrick's gave evidence. Mary Madden, who had worked for the Northern Ireland Office in the final years of our remit when the NIO bore responsibility for the training schools, and Karen Pearson, who represented the Department of Justice and the then Department of Health and Social Services and Public Safety, gave evidence. The Diocese of Down and Connor, the De La Salle Order and the Health and Social Care Board were also represented as core participants.

4 We are indebted to all these witnesses for providing their accounts of events at St Patrick's. We are aware that recalling difficult times and presenting evidence in a public hearing will have been stressful for many witnesses, but both the written and oral evidence was invaluable in providing a full picture.

The Aims of St Patrick's

5 The draft handbook for Slemish House laid out the overall aims of St Patrick's:

> "As a Christian school, the staff of St Patrick's attempt to establish, maintain and adhere to Christian ethics and values. These values lead us to believe that all persons are children of God and that service to anyone in need is rendered to God himself. Each boy is accepted for who he is and not for what he does or has done. This attitude reflects belief in the basic dignity of the person which leads us to a more caring society and helps us to remain responsive to the special needs of youth by a greater sensitivity of changing times.

6 "Whatever is done in St Patrick's is intended to help each boy grow in awareness of his own goodness and worth. Ultimately, it is this awareness which makes possible a more fulfilled, more responsible and more constructive life.

7 "While respecting individual differences, St Patrick's provides the young person with the secure setting needed for growth towards adulthood. This security is found, primarily within a community of caring, supportive and understanding people. Although the degree of personal involvement varies, no staff member - Caring, Teaching, Medical, Ancillary - is unimportant. Meeting needs, actualising potentials and developing skills are essential elements in the school programme. Dealing with irresponsible behaviour must also be included. Irresponsible behaviour is damaging to the sense of self-worth and the good of others and therefore, must be opposed by all who care. Wisdom, as well as active concern, is needed to turn occasions of irresponsibility into opportunities for personal growth and understanding.

8 "In living this philosophy, our contribution to a young person's life is to enhance his opinion of himself and heighten his regard for others".[1]

9 These aims are clear and straightforward, and appear to be consistent with the ideals of the De La Salle Brothers. Although they were drafted prior to the opening of Slemish House, they probably reflect the values which underpinned St Patrick's from the start.

1 SPT 18309-18310.

The History and Role of St Patrick's

10 In 1869, as soon as the Industrial Schools (Ireland) Act 1868 was passed, Bishop Patrick Dorrian, the Roman Catholic Bishop of Down and Connor, established St Patrick's Industrial School in Donegall Street in the centre of Belfast with an initial intake of 20 to 24 boys. In 1870 the Diocese leased Milltown House in the Falls Road area; this site was on the western edge of the city at that time, and it included a five-acre farm. For a short period both sites were in operation, but on 11 January 1873 St Patrick's moved to the Milltown site and it remained there for nearly seventy years.[2]

11 The school was under the management of a Board comprising the Bishop of the Diocese as Chair and five or six parish priests or administrators as well as the Vicar General of the Diocese. At a meeting on 5 March 1917 there was discussion about the De La Salle Order being invited to take charge of the school. There were adjournments of the Committee meeting, and representatives of the Order attended the Committee on 12 March, a final decision being made on 2 April that the Brothers would take charge of the school on 1 May 1917. They continued to be in charge of St Patrick's until 1995, and were therefore responsible for the running of the school throughout the period covered by the Inquiry's terms of reference. They remained accountable, however, to the Diocesan Committee until the 1980s.[3]

12 With the partition of Ireland it became apparent that there were no reformatories for boys in Northern Ireland. Brother Peter Marron was appointed head of the school in 1922 and it was during his time that St Patrick's was designated as a reformatory for Roman Catholic boys as well as an industrial school.[4] As a reformatory it admitted young offenders, and throughout the rest of its history there was an ongoing concern about the differing needs of the boys admitted for 'care' and those sent there for 'justice' reasons. As early as February 1924 the Committee minutes record that:

> "... in the opinion of the Committee [it] is undesirable to have Ref. Boys in the same Estb. with Industrial Boys. We recom. that provision be made for these Ref. Boys elsewhere."[5]

2 SPT 842-843.
3 SPT 842-843.
4 RUB 039.
5 SPT 843-844.

Reformatory boys were generally in the minority, but the proposal that they should be moved to separate provision suggests that the Committee wished to revert to their pre-partition remit.

13 During the Second World War, following the air raids on Belfast, premises were acquired at Alexander House, Forkill, in County Armagh, near Dundalk, and 62 members of the junior school transferred there from May 1942 to March 1944.[6] The overall number of places was increased to 225.

14 A photograph of the Milltown building shows a large house with a substantial extension built to house the boys.[7] BR 26, who worked there for the last six years that these premises were in use, described it as "an old ramshackle building". He was sited with thirty boys down the lane in a building formerly used as a mill, but most boys were in the main building. He said that conditions were "grim", but were tolerated as they did not know of anything better.[8]

15 BR 26 described the boys admitted in the 1950s as very different from those who were in St Patrick's in later decades. They often came from broken homes or had been truanting. Some were admitted voluntarily on a charitable basis. The offences which had been committed by boys were generally more trivial.[9]

16 As early as February 1943 it was decided to move to new premises "at the earliest possible date" and on 30 August 1943 a 99-acre site was purchased on Glen Road, about a mile from Milltown, but further out of the city. Plans were submitted to the Ministry of Home Affairs in January 1946 but it was 1 September 1957 before the new buildings were officially opened by Bishop Mageean.[10] It is unclear why there was such a delay in building the new premises.[11]

17 The new buildings were described as a model training school with excellent facilities, and in their early years they attracted a lot of distinguished visitors, such as the Mayor, the High Sherriff and government Ministers. BR 26 said that the new buildings bore no relation to the Milltown site. The buildings were not complete when they moved in; the swimming pool,

6 SPT 30105.
7 SPT 10026.
8 Day 157, pp.23 to 24.
9 Day 157, pp.24 to 25.
10 SPT 846-847.
11 SPT 846

for example, was finished later, but over the years the site continued to be improved. He described the Glen Road site as "a dream come true".[12]

18 However, in some respects the model was already dated. In its overall size, the school was going against the trend towards smaller units, and in having dormitories for 20 boys, St Patrick's was running counter to the Home Office guidance issued in 1952, in which it was recommended that large institutions should be broken down into smaller family-sized groups. The school remained on this site until its closure, and almost all the evidence of witnesses relates to the Glen Road site.

19 The Committee's view that St Patrick's should revert to its industrial school model and cease to admit reformatory boys appears to have changed over time. Under the influence of BR 39, then the head of St Patrick's, when Rubane House at Kircubbin was purchased by the Diocese in March 1950, it was decided that Rubane should be registered as a voluntary home for boys,[13] that is, admitting boys in need of care rather than young offenders, and a group of boys was transferred from St Patrick's to the new home, leaving St Patrick's with its mixture of reformatory and industrial elements unchanged.

20 Under the Children and Young Persons Act (Northern Ireland) 1950, reformatories and industrial schools were all renamed training schools, blurring the distinction between the care and justice elements. St Patrick's became a training school (though like the other training schools it was also registered as a remand home), but the debate about the distinction between the two groups continued, both professionally and politically. There were, for example, those who argued that there was no clear division between the two groups, that those in need of care often presented more disturbed behaviour than the offenders, and that some children fell into both groups.[14] In England and Wales it was decided to abandon the distinction and under the Children and Young Persons Act 1969 all children in need of any form of care were outside their homes committed under Care Orders. It was common practice for English legislation concerning children to be replicated in Northern Ireland, but in this instance, by contrast, in 1979 the Black Report recommended that the two groups should be treated separately, and following the Prior Compromise in November 1986, St Patrick's was reorganised into a Justice Unit and a Care Unit, which were run separately on the one site.

12 Day 157, p.26.
13 SPT 845.
14 Day 164, pp.7 and 8.

21 From 1969 onwards the justice side of the school was placed under additional stress during the Troubles, as a number of boys were admitted because of their involvement in civil disorder. Lisnevin, which was secure and non-denominational, was opened in 1973, and presumably eased the workload for St Patrick's. However, the Troubles created tensions between the 'care' boys and the 'justice' boys, and is dealt with further below.

22 In addition to the division between care and justice, the other main distinction in the overall structure of St Patrick's was that it was divided into a senior side and a junior side. Indeed they were listed as St Patrick's Senior School and St Patrick's Junior School. Although they were on the same campus under the control of a single Brother Director, the two sides functioned as totally separate schools, sharing only a few resources in common, such as the chapel, the sports hall, the office and the central kitchen. One witness said that, as a junior, he only saw senior boys through the hatch when they served food in the canteen. There appear to have been a few joint activities, such as the weekly mass and football competitions at Christmas time, but in effect the two schools were distinct. It would appear that twenty of the 24 applicants who have come forward to the Inquiry were probably resident in the Junior School, whereas two of the witnesses put forward by the Order were in the Senior School.

23 The junior side focused mainly on schooling, though it also had workshops to offer trade training to boys who reached school leaving age. The senior side focused primarily on preparation for work through trade training. Boys were allocated to one side or the other depending primarily upon their age on admission, with a cut-off point of about fifteen and a half to sixteen. The allocation of boys also depended in some cases on other factors as well as age, such as the maturity of the boy, his behaviour and the type of offences in which he had been involved. With occasional exceptions boys did not move from one side to the other, unless they were discharged and were made subject to a second Training School Order when of senior age.

24 It appears that in general there were more boys admitted to the junior school than the senior and more on the care side than the justice side.

Age on admission	Boys admitted for assessment in 1994 (SPT 12638)	Applicants to the Inquiry where ages are known or can be estimated
9	-	1
10	-	-
11	3	1
12	5	1
13	7	9
14	5	7
15	6	2
16	4	2
Total	30	23

25 It will be noted that in both columns relatively few boys aged 12 and under or aged 16 were admitted, and that the peak age for admission was 13. Typically, the majority of boys were admitted to the junior or care side for a couple of years at the end of their schooling. The older boys were placed in the senior school and were more often on the justice side. In the later years there was a move from a senior/junior split to a care/justice split, but this was gradual and seemed to reflect the intake, rather than being policy-driven by the Black Report.

26 The buildings at Glen Road came to be seen as institutional, and chalets were built to house smaller groups of boys. Although it had been heralded as a model institution when it was opened and had been in use for only forty years, the main building fell into disrepair and was demolished in 1996.[15] The Department planned to close St Patrick's, but its proposals met with a sharp reaction, and, perhaps recognising the concerns expressed by the Catholic Church, in 1995 the government agreed to fund additional new buildings.

27 Over time there were reductions in the number of boys admitted to St Patrick's. Its closure coincided with a number of major changes, which took place around the end of the Inquiry's remit. The Children (Northern Ireland) Order 1995 wound up the training school system in 1996, and St Patrick's became Glenmona Resource Centre, which was no longer specifically for Roman Catholic children. With the appointment of increasing numbers

15 SPT 10002.

of lay staff, the De La Salle Brothers had become a smaller proportion of the overall staff team and they ceased their formal involvement in 1995, though one of the brothers who gave evidence remained on the staff of the new centre until 1997. The Resource Centre finally closed in January 2001.[16]

28 Throughout its existence, therefore, St Patrick's had a demanding role in being expected to contain, control, care for, educate and train large numbers of boys who had histories of offending and disturbed behaviour. Some of them came directly from the courts, either as offenders or in need of care, but in some cases they were transferred from other establishments as the staff of children's homes could no longer cope with their behaviour. In the early days there were also 'voluntary' admissions when parents approached the school to seek a place for their son.

29 For much of its history, St Patrick's had notional figures of 80 juniors and 80 seniors, totalling 160 boys, but the numbers fluctuated considerably. They ranged from 167 in 1917 to 87 in 1931, with a peak in 1943 of 235. In 1965 there were 147 boys present.[17] At an inspection in December 1993, there were 98 on the roll.

30 In view of its size, it will be appreciated that St Patrick's played a major role in meeting the needs of Roman Catholic boys from the whole of Northern Ireland throughout its existence. In total 4,537 boys were admitted.[18] We have received evidence from 31 former residents; we have records of a further 39 who gave evidence to the police or have made civil claims against the Order. We have therefore only received evidence from 70 people in all, or just under one and a half per cent of the total number of boys who passed through St Patrick's.

31 Clearly, we cannot be certain why more witnesses have not come forward, but we have to make the assumption that fewer people were discontented with the quality of care which they received than in some of the other large homes we have examined where higher percentages of former residents have come forward. This assumption is supported by the fact that, although there are some serious allegations about sexual and physical abuse, very few complaints were made about other aspects of the care, education and training offered by St Patrick's.

16 SPT 10003.
17 RUB 063.
18 SPT 54528.

Governance

32 The school was registered by and accountable to the Ministry of Home Affairs until the end of 1972, when the Northern Ireland Office took over on foot of direct rule.

33 There was a Board of Management in accordance with the Training School Rules. The Board was chaired by the current Roman Catholic Bishop of Down and Connor and it was made up of local clergy. On 2 February 1954 the Board considered a letter from the Ministry of Home Affairs, drawing to their attention the Rule that at least two members of the Board had to be women. By way of response:

> "The Manager was instructed to write to the Ministry informing them that the Board did not consider it advisable to change its present constitution."[19]

There is no evidence that any action was taken to modify the Board membership for over thirty years.[20] Following the critical inspection in 1988 the number of priests on the Board was reduced and the number of lay people increased.[21]

34 The Board was required by the Training School Rules to meet at the school on a monthly basis. During the Troubles they met only every six months, and while this was understandable as travelling was at times difficult, it was also unfortunate as the staff needed additional support at that time. They did not meet, for example, for five months after the death of Bernard Teggart, which is considered in more detail below.

35 The Board had two main subcommittees. One was the Licensing Committee, whose membership included people from the wider community, and it met once a month. It received reports from housemasters, reviewed the progress of boys and recommended their discharge under licence when it felt they were ready to move on.[22] Boys could attend the Committee if they wished. Typically boys had to remain at St Patrick's for at least a year before they could be discharged, but exceptionally the Committee could seek special dispensation for discharge at an earlier date from the Secretary of State.

19 SPT 10446.
20 SPT 846.
21 Day 145, p.108.
22 Day 157, pp.61 and 62.

36 The second subcommittee was a General Purposes Committee which oversaw the daily life and management of the school.[23] There were also occasional subcommittees set up for specific time-limited purposes, such as the development of the West Side Project.[24]

37 SPT 2 said that the staff had very little contact with the Management Committee.[25]

Finance

38 Unlike the large children's homes with which the Inquiry has had to deal, finance was not generally a major problem at St Patrick's, possibly because it was fulfilling a statutory role as an industrial school, and from 1950 as a training school. In its earlier years as an industrial school, St Patrick's was funded in equal measures by capitation grants from central and local government (£1 per week in 1942), with parents contributing when they placed their children voluntarily, though the income was minimal.[26] The School also received at least one legacy, amounting to £2,000.[27] The over-riding principle under the 1950 Act was that the funding of training schools was seen as a central government responsibility, and training schools were therefore funded directly. Although there was a point in the 1940s when there were discussions involving the Minister, the funding was generally sufficient to provide acceptable living conditions and the level of staffing deemed necessary at the time. Furthermore, when requests were made for increases in expenditure, St Patrick's received positive responses.

39 While the Diocese of Down and Connor purchased the Glen Road site, it was the government which provided capital for the new building. The Trustees took out a mortgage with the Minister of Finance, and repaid it in annual instalments from the Department's grant. Further developments were financed in the same way in 1954, 1957, 1968 and 1971, to provide a gate lodge, classrooms, a pre-licence hostel, playing fields and other facilities, as the site was developed.[28] Some difficulties were encountered when the Evangelical Protestant Society objected to the government financing the chapel, but a compromise was reached whereby a gymnasium was financed, which was capable of doubling as a chapel.[29]

23 Day 157, pp.113 and 114.
24 Day 157, pp.62 and 63.
25 Day 143, pp.100 and 101.
26 RUB 040.
27 SPT 10547.
28 SPT 847, 10001.
29 SPT 847.

40 Br Lawrence O'Toole, Assistant General of the Order, was quoted in 1957 as describing the Ministry of Home Affairs as "liberal and benevolent", a "fairy godmother."[30] In oral evidence, BR 26 underlined this point, saying that St Patrick's obtained whatever it needed.

41 However, during the 1980s some of the buildings became very run down, and it was only after a critical review in 1990 and some tense negotiations that funding was provided by the government to update the premises in 1992-5, provided £1.9 million to build two extra house units and refurbish two existing ones.[31]

The Glen Road Buildings and Site

42 Prior to the building of St Patrick's, the Glen Road site had been farmland, and the farm, which was on the northern edge of the premises, remained a working farm. The site as a whole covered 100 acres, which gave considerable scope for development and redevelopment to meet changing needs.

43 The approach was by way of a set of gates off Glen Road. There was a gatekeeper's house, and it was the role of the gatekeeper to check incoming vehicles. There was then a longish drive leading up to the main campus. The main building had two long wings - one for the Senior School and one for the Junior School - separated by a corridor.[32] There were classrooms and other shared facilities on the ground floor, and there were two upper floors of dormitories. On each side there was a pair of dormitories on each floor. The pairs of dormitories were grouped at right angles to each other, forming an L-shape, and at the corner of the L a brother had a bedroom, with internal windows so that he could observe the two dormitories, though later these rooms were used as bases for the nightwatchman or as offices.[33]

44 Over time about two dozen other buildings were constructed, scattered around the central campus, providing offices, a house for the brothers, a chapel, a sports hall, a swimming pool, chalets as living quarters for the boys in the later years, schoolrooms and trade training workshops. There were playing fields, and beyond them the fields still used for agriculture. Black Mountain rose up beyond the farm, providing a backdrop for the site as a whole.

30 SPT 653.
31 SPT 10002.
32 Day 143, pp.29 and 30.
33 Day 140, p.38.

45 Clearly the use of buildings changed in the course of time. In the early decades, as described in the history above, the main building housed the two schools and some of the shared facilities, but several chalets were built to provide a more homely setting for the boys. Two of the chalets in particular figure in the history of allegations of abuse at St Patrick's - Aisling House, which was used for reception and assessment, and Slemish House, which was initially designated to prepare senior boys for discharge but was later used by the junior school as a small secure unit to offer intensive care. They are described more fully below. The chalets included staff accommodation, and more staff housing was provided nearer the road. The availability of staff accommodation helped to ensure that, in addition to the resident brothers, there were people around to assist in emergencies. However, SPT 2 said that most staff returned to their homes in Belfast, and unlike many similar institutions, St Patrick's did not become a closed community. Indeed, there was little interaction between the staff of the two schools.[34]

46 With such a large site there were a number of ways to enter and leave other than the main drive, and during the Troubles one of these paths became known as the Ho Chi Minh trail because of its clandestine use by soldiers and others at night time. The path led directly across the Monagh Bypass to the Turf Lodge estate, which was nearby, and it was a quick way for absconders to reach the city while avoiding the main drive.[35]

47 Towards the end of St Patrick's existence, as the number of boys was reduced, less was spent on the maintenance of buildings and facilities such as the swimming pool and play hall fell into disuse, reducing the opportunities for activities for the remaining boys, and the main building was demolished in 1996.[36]

Daily Life

Admission

48 When he was admitted to St Patrick's in 1957, HIA 314 was shown up to his dormitory and given clothes to change in to:

> "I was given a number and I had to sew that number onto all my clothes. I was given washing and dental gear as well. The clothes were

34 Day 143, pp.103 and 104.
35 Day 147, pp.138 and 139.
36 Day 143, p.53.

of reasonable quality, I'll say that much. We had to do our own private washing - our underwear and socks but the big washing like sheets was sent away. Every Friday night we were issued with a linen bag with our clothes in it for the next week and we put our old clothes in the bag to be sent away to be washed."[37]

The Daily Round

49 HIA 314 also provided a clear picture of the daily round for the boys:

"The daily routine in the home was we were woken at 5.30 a.m. by a hurley stick being banged along the ends of our beds or a whistle being blown by a civilian worker. We washed and dressed, and then we were sent back to the dorm to clean and tidy and make our beds. We had breakfast after that. We had all our meals in a large dining room. There were four boys at a table and there was always a mad scramble for food, especially on Tuesdays and Thursdays when we got baps. You would have to run to your table, grab your bap and put it down your shirt. We were always hungry in the home.

50 "After breakfast we were put out into the yard, no matter what the weather was like. Then after a period of time we either went to school or to technical workshops. These were both on site. I went to the woodwork shop. Other boys went to the craft workshop where they learned how to weld, and others worked on the farm. I remember I made a statue of the Pope once and a dressing table for one of the Brothers. I used to make racks and things for people on the outside as well who I didn't know. At school, we were given the strap on our bottoms for any minor offence such as looking at each other in class.

51 "After our workshops, we would be given more work to do like cleaning the corridors, showers, toilets or changing rooms until supper time. After supper we went outside and waited until the civilian workers let us inside to watch television. They had the keys and we would have to stand outside until they decided to let us in. ... If it was raining there was only one place to shelter and we used to fight for that spot but then the Brothers would punish you for fighting.

52 "We were sent to bed very early while it was still daylight outside. We could hear people still playing outside but we had to go to bed. At bedtime the Brothers helped the younger boys into their pyjamas. We had to sleep in pyjamas only and they checked you weren't wearing your underwear underneath. One of the civilian staff patrolled the

37 SPT 001-002.

dorms regularly during the night. The lights were never put out; there was always a light in the form of a statue in the centre of the floor on a pedestal."[38]

HIA 314 had sadly died before giving evidence, and so it was not possible to obtain his oral evidence, but we noted the Order's comment that he maintained contact with St Patrick's, and in particular Br Stephen, after he had left.

53 HIA 282, in explaining his fear of the brothers, described bedtime:

"Christian Brothers would come round to turn the lights out ... Once we knew a Brother was coming you could have heard a pin drop in that dormitory and before he turned to go into that dormitory everybody was in bed and ninety per cent of the boys were lying on their side with their eyes closed pretending to be asleep, that's how terrified they were of the Brothers. We would have been sitting on somebody's bed talking away and we were like rockets getting into bed. If you were not in bed he would have used the strap to slap your leg."[39]

Food

54 There were witnesses who said that they always felt hungry or that the quantity of food was insufficient, but these did not seem to be their main complaints and did not amount to neglect.

Clothing

55 SPT 2 said that the nuns used to keep a stockpile of clothing from which the boys were kitted out, but that after he had observed child care practice in children's homes on his qualifying course he introduced supervised shopping for clothes in shops in Belfast. He said that changes of this sort were introduced through staff meetings, and that the younger brothers were more prepared to change.[40]

Religious Observance

56 In the earlier years Mass was said daily, with the Angelus in the evening.[41] In later years compulsory Mass was limited to Wednesday evenings and Saturdays. On these occasions all the boys attended from both senior and junior sides, or later the care and justice units.[42] Unlike the

38 SPT 002-003.
39 SPT 043.
40 Day 143, p.38.
41 SPT 006.
42 Day 145, p.33.

evidence concerning some other children's establishments, there were no complaints from former St Patrick's boys about the level or type of religious observance required of them.

Schooling and Vocational Training

57 Although they spent much of their week time in classrooms, the witnesses did not make much mention of schooling. According to HIA 272 the school was "massive":

> "There were around thirty boys in each class and in my time there the boys moved from class to class for different subjects rather than staying in the same classroom".

The teachers included both brothers and lay staff. He did not recall ever having any homework in the evenings, and at times he was given domestic chores to do instead of schooling.[43] Some witnesses alleged that they were diverted from the classroom onto work around the school, such as cleaning or laundry.[44]

Classes in the junior school were reported to have been divided by ability. HIA 227 described the quality of education as "basic" and noted the absence of homework.[45]

58 SPT 125 said that on admission to St Patrick's he had not been considering higher education as an option, but influenced by the advice of BR 26 he stayed on to do A Levels, attending a day school run by the De La Salle Order in Andersonstown. He also read a lot, and thinks he was seen by the other boys as an oddity. Having done clerical work in a temporary summer job, he stayed in post rather than go to university, and went on to have a successful career in the Health Service. Indeed, SPT 125 felt he achieved more than if he had not attended St Patrick's.[46]

59 When the new school was planned, vocational training was to be offered in woodwork, metal work, French-polishing, shoe-making and tailoring.[47] Among the trades taught in the senior school were brick-laying, painting, farming and joinery.[48] HIA 314 was taught cabinet-making and he was doing well, so they decided to keep him on.[49] Indeed the quality of the

43 SPT 082-083.
44 Day 138, pp.155 and 156.
45 Day 140, p.118.
46 Day 140, pp.71, 74, 84, 92, 102.
47 SPT 10006.
48 Day 143, p.32.
49 SPT 49452.

training received by St Patrick's boys was such that employers sought them.

Activities

60 BR 26 said that there was a considerable emphasis on sport and recreation, and that St Patrick's achieved a good reputation. Teams were invited in to play St Patrick's, and "the home boys were the team to beat."[50] There were weekly trips to the cinema and to swimming baths. BR 43 taught swimming and BR 94 said that the School was barred from competitions for winning too much.[51] There were summer holidays at Glenariff in a house leased from Senator Joseph Maguire, where the boys stayed in groups of forty for a month at a time.[52] In 1946 a band was set up by SPT 90, with up to fifty members, and they travelled widely to give performances.

Medical Care

61 We have received no significant complaints about the medical and nursing care provided by St Patrick's. From 1945 there were two nuns of the Bon Secours Order who acted as nurses, but they were withdrawn in 1975 because of a shortage of nuns and their place was taken by members of the Franciscan Missionaries of Mary, who assisted in housemothering.[53] As described below, HIA 314 alleged that the nuns did not pass on his complaint about abuse. A doctor visited weekly.

62 When necessary, hospital care was arranged. HIA 219 had longstanding problems with soiling. He was referred to the Royal Victoria Hospital, and it is clear that the staff were persistent in helping him overcome this problem.[54] In an inspection report dated 29 November 1950 the introduction of the bell and pad system to deal with enuresis was recommended as it was then being trialled by the Ministry.[55]

Overview of Daily Life

63 Clearly, the daily round changed over time, in particular with the opening of the chalets, but the picture provided by other witnesses was broadly consistent with HIA 314's account. Staffing was thin at that time and the

50 Day 157, p.27.
51 Day 147, p.42.
52 RUB 061.
53 RUB 064.
54 SPT 47883-47926.
55 SPT 10384-10385.

school's finances would have been stretched, but HIA 314's only criticism of living standards was that he was always hungry. The daily round was organised to ensure that necessary tasks were all fulfilled, that the boys had a range of activities (household tasks, class work, trade training, time out of doors and leisure), and that supervision was maintained. The picture presented by HIA 314 and others is of a well organised institution, set up to deal with boys who could present difficult behaviour, which functioned in accordance with the standards of the time, and it seems that it ran smoothly.

Case Management

64 Rule 46 of the Training School Rules placed a long-standing obligation on the Managers to review boys' progress and provide aftercare. As social services were developed and the number of social workers grew, they took on the responsibility of family case work and care planning in children's homes, but in training schools the responsibility remained with the Board of Management and the staff. When a boy was admitted to St Patrick's the welfare authority closed the case. This meant that contact with the boys' families was maintained by the staff of St Patrick's. They called on families in their homes, they got to know the sorts of places where boys socialised or congregated when in the community, they escorted boys to and from court, and they collected absconders. SPT 2 said that he maintained contact either when families visited the school or on home visits. He spent Wednesdays regularly in Derry, visiting boys' homes there.[56]

65 Within St Patrick's there were three systems for assessing the progress of boys. The first was the Licensing Committee, a subcommittee of the Board of Management, which had the responsibility of complying with the Rules by reviewing the progress of the boys at intervals and determining whether they were ready to be discharged under licence. Reports were prepared by the staff of the boys' units. Once they were discharged, while the boys' licences were extant they could be recalled to complete the period granted by their Training School Order at St Patrick's. HIA 314, for example, was released on licence to the care of his father on 11 May 1961.[57]

56 Day 143, pp.101 and 102.
57 SPT 49477.

66 Secondly, there appears to have been a review system run by the staff which was similar to that organised by field social workers for children living in children's homes. It appears to have considered boys' progress in more detail, including day-to-day problems and needs. It does not seem to have had any powers to decide on issues such as discharge, and it is not clear whether it had any links at all with the Licensing Committee.

67 Thirdly, within Slemish House, which provided short-term intensive care, there was a separate system to review progress with a view to returning boys to the units from which they had been referred. Again, this system was run by the staff, and included not only the staff from Slemish House but also the boys' keyworkers.

Family Contact

68 On 20 September 1994 BR 90 wrote:

> "We believe that weekend leave is a vitally important part of a child's care programme. In situations where contact with the home have broken down priority is given to the restoration of these. Experience has taught us that where home leave is not possible children become highly institutionalised and inadequate."[58]

He stressed the care that was taken to check families out, to explain expectations to them, to ensure that boys would be safe and to support the family, especially if things went wrong.

69 BR 90 was right to stress the importance of maintaining home contact, as it is one of the main predictors of successful outcomes for children in residential care. As many of the boys at St Patrick's came from Belfast, going home presented few logistical problems for them and they spent their pocket money on bus fares home. This was treated as a privilege, which encouraged boys to earn sufficient points to be allowed home, but it was a privilege which was widely granted, such that there were sometimes only a few boys left in units at St Patrick's at weekends, mainly those who had no home to go to or who were from more distant parts of the province.

70 While the boys visited their homes at weekends, many were also visited mid-week by their families, and there was said to be a trail of visitors walking up the road from the bus every Wednesday evening, often bringing extra food for the boys.[59]

58 SPT 12895.
59 Day 139, p.105

71 The contact with families was a positive feature of the care of the boys at St Patrick's, and was the other side of the coin from their absconding, which is discussed below. The use of a points system to earn the privilege was a way of controlling the boys' movements by regulating their home contact. This practice contrasted sharply with that at Rubane, where the home's siting in the countryside reduced the likelihood of absconding but also made contact with families much more difficult, whether it was a matter of the boys travelling to Belfast or their families using public transport to get to Rubane. St Patrick's boys' frequent contact with their families may also have had an impact on the likelihood of boys being abused, either physically or sexually, in view of their frequent opportunities to disclose to their parents.

Management of Behaviour and Punishments

Points System

72 There was a points system to regulate behaviour and encourage good conduct. Every Thursday there was a meeting attended by all the staff at which points were awarded for the boys' behaviour in different areas of activity such as the classroom and their house unit. Points were lost for fighting or disruptive behaviour. The boys then queued in the gym and they were paid pocket money and allowed to go home, depending upon the points they had accrued.[60] HIA 100 said that he never remembered getting the full amount of pay, which in the mid 1960s was three shillings and threepence, and there were weeks when he had no pay. He got home most weekends, but there were occasions when he was "stewed", that is, grounded.[61]

Detention Rooms

73 There appear to have been rooms in which boys could be held securely throughout the history of St Patrick's and they were subject to the Training School Rules issued in 1952.[62] Rule 39 (d) stated that separation should be exceptional and was subject to a number of conditions:

I. "No boy or girl under the age of twelve shall be kept in separation.

II. The room used for the purpose shall be light and airy and kept lighted after dark.

60 Day 143, pp.34 to 36.
61 SPT 052.
62 SPT 1611.

III. Some form of occupation shall be given.

IV. Means of communication with a member of staff shall be provided.

V. If the separation is to be continued for more than 24 hours, the written consent of the Board of Management shall be obtained and the circumstances shall be reported immediately to the Ministry."

74 We have no information about any secure rooms at the Milltown site, but there were cells sited near the kitchen when the school moved to Glen Road. From the descriptions given by witnesses these rooms did not meet the requirements laid down in Regulation 39(d) of the 1952 Training School Rules.[63] The light was said to have filtered through frosted glass bricks, and the rooms were not "light and airy". According to HIA 162 he was not given "some form of occupation" while in secure accommodation, nor were there any means to communicate with staff. There was a hard bed with half a mattress, no food and no call system. He added that he was held in the secure accommodation for three or four days, which the Brothers denied.[64] HIA 58 said that this room was known as the "sick bay".[65] "That room was part of my life for two years."[66] HIA 58 was at St Patrick's in the late 1960s; by the early 1970s, according to HIA 272 these rooms were no longer in use. They were abandoned because, being near the boiler house, they were subject to fumes.[67] Because of the absence of inspection reports for this period we have found no information to indicate that the Inspectors were concerned about the failure of St Patrick's to adhere to the Training School Rules in this respect. However, these secure rooms must have been in use for some years, and as the inspectors were regular visitors to St Patrick's they must have been aware of the conditions in the rooms, and therefore must have condoned their continuing use.

75 **We consider that the failure of St Patrick's to conform to the Training School Rules in respect of secure accommodation at this time, and of the Inspectorate to note the breaches and take action, constituted systemic abuse.**

76 Detention rooms were then set aside on an upper floor near the dormitories, but according to SPT 3 these were used less, as it was difficult to get a

63 SPT 80069.
64 SPT 110.
65 Day 139, p.12.
66 Day 139, p.25.
67 Day 147, p.16.

truculent boy up several flights of stairs, and a member of staff had to be designated to oversee the detention, reducing the staff team on duty. Boys were only detained in the cells for a few hours, till they had settled down.[68] SPT 2 said that the rooms were used only half a dozen times during his time at St Patrick's,[69] which contrasts with the accounts of witnesses who say that they were often placed in the cells, as they were used for absconders.[70] HIA 94 absconded frequently and was placed in one of these isolation rooms[71] where he said he was beaten by two housemasters.[72] SPT 3 said that the use of cells ceased in the late 1970s.[73] Although witnesses differed in their accounts of the frequency with which these rooms were used, there is no evidence that the School failed to comply with the Training School Rules.

77 Slemish House, which was opened in 1984 and is discussed in more detail below, had a secure perimeter; the whole house therefore constituted secure accommodation. The report by the Inspectors following SPT 81's death in 1994 noted the lack of guidelines for secure accommodation and recommended that the Northern Ireland Office should issue guidance for the boards of management of training schools to incorporate into their procedures.[74] They failed to mention the requirements of Rule 39 or that SPT 81, then aged eleven, should not have been placed "in separation", ie in secure accommodation at all. This matter is dealt with more fully below.

Corporal Punishment

78 Under the Training School Rules there was clear guidance on the way corporal punishment should be administered, which included the canes which could be used, who could administer canings, and how they should be witnessed and recorded. In the classroom, the Education Rules were applied, which differed from the Training School Rules. The De La Salle Order's guidelines said that corporal punishment should not be used at all. In Northern Ireland the strap appears to have been substituted for the cane. SPT 2 said that he saw the cane used in the late 1960s and the strap was in use in 1971 and that its use was recorded in the punishment book. Although authorised to use it, he rarely did so.

68 Day 144, pp.18 and 19.
69 Day 143, p.65.
70 Day 139, pp.15 and 16.
71 Day 139, pp.130 and 131.
72 Day 139, pp.142 and 143.
73 Day 144, pp.19 and 20.
74 SPT 12833.

79 Witnesses reported that there were times when they were sent to the Brother Director for punishment. HIA 227, for example, was sent two or three times to the headmaster and was punished with the strap on the hand.[75] Formal punishments were recorded and the records were checked by Inspectors; Kathleen Forrest, for example, was reported to have checked the "statutory books" on 29 November 1950.[76] SPT 52 said he witnessed the Principal administering six strokes on the buttocks in the office, and found the experience distressing.[77]

80 It should be noted that the Rules specified the use of a light cane, but the De La Salle Brothers used a leather strap. While the Regulations were based on the Approved School Rules relating to England and Wales, where caning was standard practice, in Scotland the tawse was widely used. It is possible therefore, that the strap was generally deemed an acceptable alternative to the cane in Northern Ireland, although this was not made explicit through a formal change in the Regulations. SPT 2 said that he was authorised to use the strap, but rarely did so, and never after 1973 to 1974.[78] SPT 3 said that only senior managers used the strap, in accordance with Training School Rules, and when he was promoted to be a senior member of staff he only used the strap once or twice.[79] The Order accepted that straps were used by teachers and other staff, and that some punishments were not recorded, but it argued that this only occurred as punishment for misdemeanours and was never excessive.[80] HIA 229 said that brothers carried straps in their pockets, between 18 and 24 inches in length, some being rigid and some flexible.[81] However, BR 94 stated that straps were kept in the tuckshop, and that staff were authorised to give boys a slap to check disputes or for bad language.[82]

81 It seems that formal corporal punishment went out of fashion and was abandoned around the mid-1970s, although BR 50 said that he witnessed a boy being strapped as late as 1977.[83] BR 26 said that he was personally opposed to corporal punishment as the boys had had "Enough

75 Day 140, p.121.
76 SPT 10386.
77 Day 144, p.69.
78 Day 143, p.63.
79 Day 144, p.18.
80 SPT 668-669.
81 Day 138, p.19.
82 Day 147, pp.10 and 11.
83 Day 146, pp.114 and 115.

of violence in their lives already".[84] Corporal punishment in the classroom was not permitted following its abolition under the Education (Corporal Punishment) (Northern Ireland) Order 1987. Corporal punishment was still permitted by the Training School Rules up to the point of St Patrick's closure in 1996.[85]

82 The majority of the corporal punishment described by the witnesses, however, appears to have been informal. BR 94 accepted that he used the strap "sparingly" in this way.[86] It was an instantaneous response to a situation by both brothers and lay housemasters, sometimes accepted by the boys as a just punishment for misbehaviour but sometimes appearing to be unjustified and gratuitous, which was resented. HIA 282, for example, said that he was smacked and kicked for no reason.[87] HIA 314 said brothers hit the boys with keys, sticks and leather straps, often for no reason.[88]

83 During much of St Patrick's history, the use of informal corporal punishment was typical of many day schools and families; it was an accepted part of the culture, and in this respect it could be said that the staff of St Patrick's were reflecting accepted ways of dealing with misbehaviour. However, during the period covered by the bulk of the allegations, such punishment breached the Training School Rules, it was contrary to the Order's guidelines, and it was unacceptable as professional child care practice.

84 **We consider the use of informal corporal punishment was systemic abuse.**

Supervision of Dormitories

85 HIA 100 said that boys were put in charge of the dormitory and if there was misbehaviour a boy might be made to kneel in front of a statue of St Patrick in the middle of the dormitory and pray with his back "bolt upright". If a boy then slouched he was made to kneel on the tiles in the corridor "all night". Kneeling for long periods was most unpleasant for the boys affected and although schools often designated older boys as prefects it was unacceptable practice to delegate authority to punish other boys in this way. The brothers whose rooms were attached to the dormitories had

84 Day 147, p.72.
85 Day 145, p.8.
86 SPT 2176.
87 Day 141, p.81.
88 SPT 010.

a small window with a venetian blind so that they could observe the boys' behaviour, and they therefore should have been aware of this practice.[89]

86 HIA 272 spoke of being made to kneel on the floor for two hours in the event of misbehaviour at night, and added:

> "In other cases if anyone misbehaved they waited until about three or four in the morning and they brought everyone down and put us through cold showers. ...it could have happened maybe three or four times in six months."[90]

This type of punishment was unacceptable both because of the inhumanity of depriving boys of sleep in this way and because a whole group should not be punished for the misbehaviour of individuals. The Order is of the opinion that this recollection is inaccurate, partly because every dormitory would have been visited by the night supervisors every thirty minutes, and partly because no other witness recalled this type of punishment.

87 As variants on this account were provided by other witnesses, it appears to have been standard practice and it could therefore be termed systemic. Furthermore, under Rule 45 of the Training School Rules, it was stated:

> "No pupil shall be allowed to administer any form of punishment to any other pupil."[91]

88 **We consider that permitting older boys to punish others when supervising them in the dormitory was a breach of the Training School Rules and was systemic abuse.**

Other Informal Punishments

89 HIA 229, for instance, resented the action of 'Br Philip' when he had been given permission to return late after a concert:

> "'Br Philip' removed my mattress and my bedding and I was forced to sleep on the springs. ...This was the type of punishment for no reason which some Brothers really enjoyed."[92]

The Order have told us that there was no Br Philip at St Patrick's. HIA 229's account suggests that, whichever brother was involved, this action was an inappropriate and spiteful misuse of authority, and so clearly constituted unacceptable practice, but there is no other evidence to confirm that it

89 SPT 048.
90 SPT 080.
91 SPT 1612.
92 SPT 010

was more than a one-off incident and we do not regard it as systemic abuse.

90 HIA 275 said that towards the end of the 1980s:

> "I was stripped naked and forced to stand in the corner of the common room for hours on end. I was told it was to stop me running away so much. …This type of punishment happened on at least seven or eight occasions". The member of staff responsible was HIA 275's keyworker, and HIA 275 considered him a bully.[93]

91 Frequent absconding must have been exasperating to staff, and they may have been at their wits' end to know how to help HIA 275 settle. However, his keyworker should have been the person to whom HIA 275 could turn for support and care, rather than his main tormentor. The punishment applied was humiliating, cruel and counter-productive as well. **The humiliation of stripping a boy naked to stand in full view on a number of occasions constituted systemic abuse.** Other examples of informal punishments are dealt with below under the heading of physical abuse.

The Impact of the Troubles on St Patrick's

92 The Troubles commenced in 1969 and continued with varying levels of unrest and violence throughout the remainder of the existence of St Patrick's. They had a direct impact on the school in a number of ways. As noted above, St Patrick's was sited on the south-west edge of the city of Belfast and some of the most dangerous areas during the Troubles were within walking distance of the school. Indeed, there was an army base sited next to St Patrick's, and the School was hit once by crossfire, and damage was done to the brickwork.[94] As the staff were aware, the families of some of the boys were seriously affected: some were threatened and told to leave their homes. In other cases, houses, and indeed streets, were burnt out, so that in Belfast a great many families had to be rehoused.[95] In some cases the fathers and brothers of boys at St Patrick's were arrested. Boys were understandably worried about their families' safety, and this was said to be one cause of absconding.[96]

93 SPT 19
94 Day 148, p.103.
95 SPT 141.
96 Day 157, pp.40 and 41.

93 There were reports that gangs of men infiltrated the premises at St Patrick's, and this frightened the boys. HIA 162 wrote:

> "The major problem I had during that time was with the IRA. I know that on one occasion the night watchman allowed masked men into the dormitory where I slept in order to give me a punishment beating. There were a number of other boys around when these masked men arrived and there was a mass fight. The masked men then made off because of the commotion. There were never any Brothers around when this was happening. The nightwatchman later told me they would say I was found wandering outside the dormitory."[97]

In oral evidence HIA 162 said that the masked men got in through a door which was normally locked, and the brothers were all absent at the time.[98]

94 BR 26 recalled a time when two paramilitaries called and requested two boys to help with an assignment. He told them that he would need to seek parental permission first and "luckily" they left.[99] The army would not permit them to shut the gates, and so people visited St Patrick's in stolen cars. The army also made a hole in St Patrick's perimeter fence. In the circumstances BR 26 felt that there was "only so much that they could do."[100]

95 This was not just a question of infiltration from outside. HIA 162 continued:

> "The Training School had a number of boys who had been remanded there due to suspected involvement with paramilitaries. There was a lot of Republican involvement in the school at the time and the Brothers seemed to let them do what they wanted and seemed to support them. I had the impression that they were treated a lot better than people such as myself who were not involved in that type of activity. ...The Brothers became very anti-IRA after a while."[101]

96 This was echoed by HIA 54, who saw St Patrick's as:

> "a recruiting ground for Fianna Eireann, the junior wing of the Provisional IRA".

He was approached by another boy with recruiting material, but rejected the approach. Like HIA 162 he considered the brothers to be sympathetic

97 SPT 108.
98 Day 140, p.37.
99 Day 157, p.36.
100 Day 157, p.39.
101 SPT 108.

to boys who were in St Patrick's for paramilitary crimes and they "seemed to get an easier time."[102]

97 In oral evidence BR 26 said that at one point a group of senior boys planned to set up an IRA unit in the school and abduct staff. BR 52, who was then the Principal, went to the Northern Ireland Office where a civil servant gave BR 52 Máire Drumm's phone number. They met in Andersonstown and she then met the head of the group, telling him to forget the idea.[103] BR 26 observed that the Brothers had no preparation for dealing with such things.[104]

98 In the wider community, the republican movement was split into the Provisional IRA, the Official IRA and other factions, and a bitter internecine war was being fought. This was at times replicated within St Patrick's. HIA 162 again:

> "There were gangs at St Patrick's and there was a lot of bullying. The brothers knew what was going on and they watched from the sidelines. They only intervened if things got very serious."[105]

BR 26 acknowledged this problem, and spoke of factions within the boys' group, with different allegiances making the situation very volatile.[106]

99 When absconding, there was always the risk that boys would become involved in further offending or behaviour which put them at risk. Joy-riding became popular; cars were frequently stolen, ridden around at speed and then burnt out. Indeed, it became necessary to carry a passenger to mind one's car when shopping or going on errands to prevent it being stolen. It was illegal to leave unattended parked cars in the city centre, and drivers could be fined or their cars might be destroyed by the army. At St Patrick's brothers took boys with them to mind the school's car or to undertake the errands while they remained with the vehicle.

100 In addition to the men who infiltrated the school, there were army patrols, and the boys, some of whom had been involved in rioting before admission to St Patrick's, at times threw stones at them. The Brother Director spoke to the army officer responsible, who was very courteous, to persuade him to reduce patrols, but the immediate effect was that patrols were increased in size.

102 SPT 152.
103 Day 148, pp.104 and 105.
104 Day 148, p.107.
105 SPT 107.
106 Day 157, p.35.

101 For some boys, the school acted as a refuge from the Troubles. HIA 272, for example returned from absconding as the "Fianna boys" were going to give him a hiding. SPT 125 said that, but for the advice of BR 26 to keep his head down, he might well have been sucked into involvement in civil disorder.[107] For others, such as HIA 162, the Troubles provided cover when they absconded and were running wild, as they were able to stay in areas where the police would not come.[108]

102 BR 26 said that the introduction of the Diplock courts caused St Patrick's considerable difficulties. First of all, the school was faced with additional demand for places. At one time they had eight boys in their care on murder charges. On another occasion, after civil disturbance they were required to admit 23 boys. Furthermore, boys on remand were meant to be kept on the premises and not allowed home leave. This was contrary to the St Patrick's practice of maintaining close home contact and added to tension when remanded boys could see others visiting their families. In some cases remands were extended repeatedly, and BR 26 raised the matter with the Director of Public Prosecutions.[109] The regulations were not changed, but BR 26 did admit that occasionally they overlooked a boy's remand status in permitting him to leave the premises, for example as a member of a football team.[110]

103 BR 26 described the situation as "hugely difficult"; they just hoped that tomorrow would not be as bad as yesterday. He felt that they had been very successful; for example, when they had the 26 boys on remand, they managed to get 24 of them to court despite the open nature of the school.[111] The brothers were in an extremely difficult predicament. They were clearly part of the Catholic community, and as such, no doubt had sympathies with the plight of the Catholics who were rendered homeless or who were victims of shootings. On the other hand St Patrick's played an important role in the justice system; the school needed to co-operate with the courts, the police and in some instances the prison system. They have pointed out that on two occasions soldiers accidentally left weapons on the premises and that both times the guns were handed in.[112]

107 Day 140, p.77.
108 Day 140, p.33.
109 Day 157, pp.100 and 101.
110 Day 157, pp.103 and 104.
111 Day 157, p.34.
112 Day 140, p.47.

104 BR 94 said that he thought the staff deserved credit for "keeping a lid" on the factions among the boys during the Troubles. Fr Timothy Bartlett wrote on behalf of the Diocese of Down and Connor that they were:

> "acutely aware of the outstanding efforts that were made by the staff and Managing Board of St Patrick's during those uniquely turbulent and dangerous years to maintain a professional and stable environment for the residents there in the midst of the most challenging circumstances, including a prevailing culture of armed intimidation and threat by paramilitary organisations."[113]

We concur with their views.

105 Individual members of staff faced similar difficulties. They lived in the community and had to travel to St Patrick's to work, and no doubt had concerns for their own safety and that of their families.

106 All of these factors would have been elements in the backdrop at the time of the most serious incident during the Troubles, the abduction and murder of Bernard Teggart.

The Death of Bernard Brendan Teggart

107 Gerard and Bernard Teggart were twin brothers, and members of a family of thirteen children living in a socially deprived area. Their father was shot dead by the Army on 9 August 1971. The two brothers both had learning difficulties and were functioning at the level of much younger children. They were involved in petty offending and were first admitted to St Patrick's on 17 April 1968. They spent some time also at Rubane and were returned home, but were readmitted to St Patrick's on 22 April 1970 under Training School Orders.[114]

108 On Sunday 11 November 1973 a teacher, SPT 151 found three Provisional IRA men questioning Gerard in the woodwork room and they demanded that he should accompany them for an hour for questioning. SPT 151 told the men that Gerard had learning difficulties and was vulnerable, but despite his attempts to stall, they were insistent and he reluctantly agreed that Gerard should accompany them. Gerard was returned to the school an hour later as promised. SPT 151 informed BR 52, then the Principal of St Patrick's, and no further action was taken.[115]

113 SPT 3018.
114 SPT 2119.
115 SPT 2124.

109 The next day, 12 November, two different men came to the school and initially asked to take Bernard away for questioning, but then confirmed that it was Gerard who was wanted for questioning. On this occasion the Principal, BR 52, was involved, and he attempted to dissuade them, but the men appeared to be threatening and possibly armed, and reluctantly he agreed. BR 52 then left the school and went to a pre-arranged meeting in Newtownards. While he was away other men came to the school and took Bernard away for questioning. SPT 151 explained to the police that he allowed this to happen on the basis that BR 52 had previously agreed that the men could take Gerard out of the school.[116] SPT 151 explained that he became concerned when two hours had passed and the boys had not been returned and he consulted with brothers in the main office about contacting BR 52 and/or informing the police but was told to do neither thing in the meantime. BR 52 returned to the school around 5 pm, but the police were not informed about the abductions.

110 The two boys were moved around the city from house to house and were questioned. Eventually, Gerard was taken to a main road, given three shillings and an anorak; as he left, he could hear Bernard crying and screaming. He made his way home and told his mother what happened.[117]

111 When the twins were not returned by 6 pm that evening, BR 52 made enquiries, visiting the boys' home and other possible haunts.[118] Gerard was found asleep at home, but Bernard was not to be found. It was later that his body was discovered in Bellevue Park, with a label "tout" (meaning an informer) placed beside him. Bernard had been shot in the head at about 10 pm but was still alive; he was taken to the Royal Victoria Hospital by ambulance, where he died in the early hours of next morning, 13 November 1973.[119] His body was identified by the St Patrick's laundry mark, 106, on his clothes.[120] Dr Carson, the Deputy State Pathologist, conducted a post mortem and recorded death by "a gunshot wound to the head."[121] BR 52 informed the Bishop, but not the police. It was at first thought by the police that the twins had absconded from St Patrick's and they were described by the police as "escapees"; the fact that they had been abducted only came to light later when the boys' sister told the police.[122]

116 SPT 27020.
117 SPT 2121.
118 SPT 2127-2128.
119 SPT 2121, 2128, 2129.
120 SPT 2133.
121 SPT 2131.
122 SPT 2133, 2134, 2136.

112 The reason for the abductions, questioning and murder is not clear, but it is assumed that Bernard was seen by the Provisional IRA as an informer.[123]

113 This tragic event had considerable consequences. There were 263 murders that year in the Troubles, nine of which took place in Belfast that month, but Bernard's case was different and there was major public outcry. On 17 November 1973 a group of priests (Fr Denis Faul of Dungannon and Frs Aodh Bennett and Alexander Reid of Clonard Monastery) wrote to the *Belfast Telegraph*, posing four questions:

> "(1) What kind of an organisation would feel threatened by a boy with the mental age of eight?
>
> (2) What kind of 'justice' did this boy receive who was ill-treated and murdered without trial?
>
> (3) What kind of moral standards operate in people who are responsible for this child murder?
>
> (4) What kind of Irishman would condone, support or be associated with the people who did this deed?"[124]

114 The Historical Enquiries Team, which was set up to investigate unsolved cases from the Troubles, was critical of St Patrick's when it reviewed the case sometime after 2009:

> "The school had a duty of care to the boys. …That duty of care was not exercised when the school allowed the abductions, although [SPT 151] gave context to the difficulties the school was facing. His description of suspected terrorists entering the school on a regular basis demonstrates very intimidating and uncomfortable times. He also pointed out that co-operation with these groups in the past had never resulted in such tragedy."

115 "The RUC [Royal Ulster Constabulary] investigation team were very concerned at the time about the conduct of the school, its failure to give the true circumstances of the abductions and its lack of co-operation after the murder."[125]

116 It was reported in the press that the Ministry of Home Affairs undertook an inquiry into Bernard's death, but the Historical Enquiries Team could not find a copy of their report, and concluded that the school "failed

123 SPT 2149.
124 SPT 2157.
125 SPT 2151.

lamentably" in its duty of care to Bernard.[126] It was 10 May 1974 before the Board of Management met, and their discussion then focused on a claim for compensation. At that time nine boys in the school were there because of charges of murder or attempted murder and eight were on firearm charges; Board members expressed concern that such boys were in the school.[127]

117 Bernard's murderer has never been identified, but in October 2004 the IRA issued an apology, saying that "the killing should not have happened."[128] About 2009 the Historical Enquiry Team investigated Bernard's murder; despite the preparation of a full report they were unable to add to the known facts.[129]

118 In his evidence to the Inquiry BR 52, who left the Order in 1979 to become a teacher, expressed profound regret for having let Bernard down, saying that his memories tormented him.[130] That he permitted the abduction of Bernard and failed to report the three abductions to the police is clear, but his predicament when faced with the abductors was not something for which he could have been prepared. Nor was he well supported; he said that between Board meetings (which at that time took place twice a year) he had no contact with the Bishop or the Board members.[131] Whatever BR 52 had decided to do, St Patrick's was in a situation of exceptionally high risk at that time, and any judgement of his conduct now has the benefit of over forty years' hindsight. We acknowledge that BR 52's predicament was unenviable.

119 **The failure to report the abductions to the Police, however, was clearly a systemic failure on the part of the Brother Director. The failure of the Board of Management to meet immediately after the boy's death, constituted a systemic failure to investigate the incident, and to ensure that the training school provided proper care and support for both staff and boys at such a critical time.**

120 **There is nothing to suggest that the NIO took any steps to investigate whether any policies or procedures needed to be changed to protect boys from suffering a similar fate, and their failure to do so represents a systemic failing on their part.**

126 SPT 2151.
127 SPT 80296.
128 SPT 2140.
129 SPT 2111-2162.
130 Day 148, p.127.
131 Day 148, p.131.

Absconding

121 Absconding appears to have been the biggest behavioural problem for St Patrick's, and the school's failure to address the problem is probably its most significant shortcoming. BR 26 said that absconding was not a problem during the 1950s when the school was at Milltown, as the boys liked to be there, since there was little for them at home.[132] Absconding appears to have been persistent at the Glen Road site, however, throughout the period covered by the evidence of witnesses. BR 26 said that from the 1960s and 1970s onwards the boys had a 'devil may care' attitude and were fairly wild and untamed, being used to freedom.[133]

122 Several witnesses absconded on multiple occasions while at St Patrick's. A random selection of records showed that HIA 26 absconded 11 times, HIA 272 19 times, HIA 282 9 times and HIA 384 a total of 17 times.[134] At times, boys ran away in groups of eight or ten, with 12 on 8 October 1979,[135] and some frequent absconders were said to be absent more often than they were present. Again, a random selection of months indicates 38 abscondings in February 1974, 33 in April 1976 and 40 in October 1979.[136] In total, 353 abscondings were reported in the first six months of 1994, and 28 in the two months prior to SPT 81's death.[137] The problem appears to have been persistent.

123 This pattern of behaviour is important for seven reasons:

(a) The courts had committed the boys to the care of St Patrick's, and the court orders were being breached when they were absent.

(b) Absence from St Patrick's meant that the boys were at risk; no responsible adult knew where they were and they were vulnerable to exploitation or violence, especially during the Troubles.

(c) The boys' programmes of care, education and trade training were disrupted by abscondings, often at a time when they needed a period of stability in their personal lives and in their education and technical training if they were to achieve success in obtaining employment and living independently on leaving St Patrick's.

132 Day 157, p.69.
133 Day 157, p.70.
134 SPT 45052, 48978, 48251, 50117.
135 SPT 18155
136 SPT 18202, 18188, 18155.
137 SPT 12641.

(d) Absconding often signifies problems from which children are running. Several of the witnesses attributed the start of their absconding to sexual or physical abuse.[138]

(e) Well publicised research in the late 1970s showed that boys who absconded frequently committed offences, especially if they were living rough and needed money or food to survive. Some boys without previous criminal records started to offend when absconding. Offending of this sort was correlated with persistent offending as an adult, with the consequence of prison sentences. Indeed, several of the witnesses to the Inquiry had lengthy records of offending through much of their adult lives. It was therefore of real importance that any tendency to abscond should be countered as early and as effectively as possible if a lifetime of crime were to be avoided.[139]

(f) Absconding could be contagious; boys who had been progressing well could become unsettled and, if invited or pressured to abscond, they were at risk of accompanying those for whom it was already an established pattern. There was the risk that absconding in St Patrick's would be perpetuated in this way.

(g) Further offending inevitably left additional victims of the offences, affecting the reputation of the school in the eyes of the public and the services on whose co-operation St Patrick's relied; returning boys to St Patrick's must at times have seemed pointless to the police, when the boys absconded again immediately after the police had left.

124 St Patrick's faced three major problems in coping with absconding. The first is that, in being sited on Glen Road, it was on the south-western edge of the city of Belfast, a relatively short walk from the homes and haunts of many of the boys. Absconding must therefore have been tempting to any boy who was homesick or who resented curtailment to the freedom he had enjoyed prior to admission.

125 Secondly, the school was an open establishment. There were some locked doors, but it was relatively easy for boys to find a way out and a point in the daily round when they could slip away. Aisling House, for example, had five external doors from which boys could leave. In the early days,[140] according to SPT 3 because of the low staff numbers, boys were "shepherded" in groups from one activity to another by staff, thus reducing

138 HIA 253, Day 142, p.8.
139 SPT 19777.
140 SPT 12637.

their opportunities to abscond,[141] but as supervision became more relaxed such measures were dropped and it became easier for boys to run away.

126 Thirdly, from 1969 onwards Belfast was often in turmoil because of the Troubles, and this impacted on absconding in various ways. As noted above, some of the boys were directly involved in the Troubles themselves, having played minor roles in political organisations and been involved in rioting, and they were sent to St Patrick's for that reason. They attempted to recruit other boys to join them. They were presumably tempted to leave the school in order to participate in civil disorder or other activities. Indeed the problem was such that General Leng, the Commander Land Forces in the Army in Northern Ireland, later recalled the absconding of "young terrorists" from a remand institution (which we believe was St Patrick's) as a problem in the 1970s. Other boys may have absconded because they were concerned for the welfare of their families.

127 If boys absconded during the Troubles it was more difficult for the staff to travel in some areas of the city in order to search for absconders, and the police too were reluctant to enter some parts without army support, so that absconders were not followed up promptly. The Troubles were themselves unsettling and as noted above there were reports of groups of men from organisations entering the premises at St Patrick's. Their presence would have left the boys feeling insecure and would have diminished the control exerted by the staff.

128 Even allowing for these serious difficulties, the level of absconding at St Patrick's was unduly high for many years, and it does not seem to have caused sufficient concern to lead to a concerted plan of action to counter it.

129 Research has indicated that what are termed 'institutional controls' are one of the key factors in reducing absconding. However, they needed to be linked with strong 'expressive controls', "to mould and influence children's moral behaviour, beliefs and interpersonal relationships" in order to be effective.[142] In other words, in addition to physical measures such as locked doors, fences and tight supervision, staff needed to talk to boys, to ensure that they were settled and to find out what could be done if they were unsettled, in order to help them deal with their problems, and in the process to reduce their motivation to abscond.

141 Day 144, p.9.
142 SPT 19778.

130 Some action was taken. Shepherding has been mentioned before, and this was typical of the approach taken in the earlier years in training schools, so that there were fewer opportunities for boys to be unsupervised.

131 In attempting to find positive solutions to deal with absconding, the main development in the junior side of St Patrick's was the opening of Slemish House in 1984, described below. There was concern that frequent absconders were sometimes moving on to the closed establishments of Lisnevin and Hydebank primarily because of their absconding pattern and not because those establishments were more suited to meet the boys' needs in other ways. Slemish House was secure, but it only had eight beds. It was therefore only able to meet the needs of a small number of boys who were going through a disturbed phase, and its presence may have acted as a deterrent to others. It was not large enough, though, to meet the scale of absconding at St Patrick's and in the process to break the pattern. The provision of a secure unit was an 'institutional control' but it offered the chance for staff to spend time with boys in the unit to discuss their predicament, thus offering 'expressive controls' as well.

132 There were also informal attempts to punish absconders. HIA 314 said that during his time in the early 1960s absconders' heads were shaved and one shoe was removed so that the boys could not run.[143] Other witnesses reported that they had to wear shorts after absconding.[144] HIA 162 said that older boys were allowed to beat up absconders.[145]

133 Research showed that patterns of absconding varied enormously from one institution to another, sometimes being five or six times higher in one school than other establishments with similar intakes, and there were few factors which appear to be predictors. Two positive factors were that where boys were happy and contented levels of absconding were much lower, and where absconders were welcomed back absconding levels dropped. By corollary, where absconders were moved on, levels were higher.[146] We have insufficient information to judge how happy the boys were at St Patrick's or to tell what proportion of absconders were passed on to Lisnevin and Hydebank.

143 SPT 006.
144 Day 139, p.41.
145 Day 140, p.58.
146 SPT 19778.

134 SPT 26 thought that absconders were fewer as the occupancy of the school reduced.[147] However, the Inspectors in 1994 concluded that absconding levels were "very high" - a problem which staff found "very difficult to control", but which should not have been "treated as inevitable", but was requiring "a more strategic approach."[148]

135 In the Inspectors' report on SPT 81's death, it was stated that the SSI had been involved in working with another training school (Rathgael) on the subject of absconding, and a fifteen point strategy had been established which had had some success.[149] This was based on research which had been undertaken by the Adolescent Psychological Research Unit (APRU), which supported training schools in various ways. It was recommended that the strategy should be made available to St Patrick's as it had been successful in reducing absconding.[150] It is our view that this report should not have been kept confidential, when its findings were clearly of relevance to St Patrick's, and maybe other training schools and homes. It could have been shared at meetings of the principals of the schools, and a digest of recommended action could have been circulated more widely. In June 1995 the Chief Inspector, Dr Kevin McCoy, sent a minute to Sir John Wheeler, the then Northern Ireland Office Minister, about the report on the death of SPT 81, in which he observed that the "NIO was, of course, already well aware of the high levels of absconding at St Patrick's."[151] Unlike Rathgael, however, this awareness had not led to a concerted plan of action to address the problem at St Patrick's.

136 **Statistical returns concerning absconding were provided by St Patrick's to the NIO and these records would have been open to Inspectors when they visited. Prior to the concern raised by the death of SPT 81 neither the NIO nor the SSI had raised absconding as a major issue with St Patrick's and we consider this a systemic failure on their part.**

137 **The failure to circulate the APRU report's findings more widely and assist St Patrick's in finding ways of dealing with persistent absconding was a systemic failure on the part of the NIO.**

147 Day 145, p.114.
148 SPT 12649.
149 SPT 12642.
150 SPT 12650.
151 SPT 12727.

138 **Furthermore, the APRU, which had been set up as a combined unit to support all the training schools and which had undertaken the research on absconding, also failed to share their findings with St Patrick's, when they must have known that it had a similar problem.**

139 In the end, as the numbers of staff increased and the number of boys was reduced, they presumably received closer individual attention, thus providing better 'expressive controls', and it has been suggested that the level of absconding diminished when the chalets were opened,[152] though information gathered following the death of SPT 81 does not support this view.

140 The level of absconding was seen in professional residential childcare practice as a key indicator for the effectiveness of a home or school, and research suggested that schools with high absconding levels were often failing in other ways as well. In this respect St Patrick's failed, both because of the scale of absconding and because insufficient countermeasures were developed, which suggests that the problem was not taken seriously enough.

141 **It is our conclusion that the failure to take adequate measures to counter absconding constituted systemic abuse, in that it left boys vulnerable in terms of the risks they faced when absconding, in the patterns of criminality which were fostered while absconding, and in the effect of their absconding pattern on their later lives.**

The Death of SPT 81

142 The most tragic instance of absconding led to the death of SPT 81 in 1994. SPT 81 was a boy from Derry and although he was only aged eleven and a half, he was admitted to Aisling House, the assessment unit at St Patrick's, on 22 July 1994 for assessment following some serious behavioural problems at Harberton House.[153]

143 He was encouraged by four other boys to abscond on the afternoon of Sunday 14 August 1994 and they made their way through various parts of Belfast. The absconding had been planned, as SPT 81 had hidden a bag of food and clothes in advance.[154] A member of staff went looking for them, which was good practice, but failed to find them. In the early hours of Monday 15 August in the Falls Road area the boys stole and started

152 Day 140, p.132.
153 SPT 12626.
154 SPT 12641.

up a car, but SPT 81 was left at the roadside, which upset him. When his companions made a circuit of the streets he jumped out in front of the car and then jumped back. The driver swerved and missed him, but on the third time that this happened, SPT 81 jumped in the direction in which the car swerved, and he was knocked down and killed.[155]

144 This tragedy demonstrated the influence of regular absconders on impressionable newcomers and underlined the vulnerability of absconders to serious harm.

145 Three inquiries were conducted into the circumstances leading to SPT 81's death. The first was internal to St Patrick's, carried out at the request of the Board Chairman by two Board members to consider the role of the school in events. The report essentially described what had happened, and only made one recommendation - that when staff went to get the minibus they should take the boys with them, to maximise supervision.[156]

146 The second was undertaken by Bob Bunting, Assistant Director in the Eastern Health and Social Services Board, and Mr T. Haverty, Chief Social Work Adviser with the Western Board for the Western Health and Social Services Board, to examine the lead up to SPT 81's placement at St Patrick's, and so its contents have little bearing on this chapter.[157]

147 The third report was prepared at the joint request of the Criminal Justice Services Division of the Northern Ireland Office and the Department of Health and Social Services by the Inspectorate to deal with "a number of matters not fully covered" by the first two reports.[158] It was undertaken by Victor McElfatrick and Chris Walker of the Social Services Inspectorate and Robert Mitchell of the Northern Ireland Office. They were highly critical of St Patrick's, pointing out that SPT 81's vulnerability as a new boy to the influence of older established absconders had been underestimated,[159] that records suggested that the seriousness of absconding was not recognised, and that there was little indication that the reasons for a boy absconding were followed up on his return.[160] This was contrary to oral evidence from brothers who said that there was discussion with absconders on their return to understand why they had run away.

155 SPT 12629-12631.
156 SPT 12897-12903.
157 SPT 18994 – 19053.
158 SPT 12618-12651.
159 SPT 12641.
160 SPT 12642.

148 The Inspectors made a total of 23 recommendations, which covered issues as diverse as information leaflets, door alarms, policy matters, staffing and management. They recommended the introduction of an information system "to monitor absconding and develop a strategic approach to tackling the problem", the sharing of the Rathgael report on absconding, and a "fundamental review of the care arrangements" to identify ways of reducing absconding.[161]

149 The incident appears to have led to some tension between the Inspectorate and the NIO, who had expected the report to be more critical of the quality of management at St Patrick's and appeared to feel that the inspectors themselves had fallen short.[162] Victor McElfatrick responded to these criticisms with a memorandum to the Chief Inspector Dr Kevin McCoy.[163]

150 We have already mentioned that St Patrick's failed to develop a strategic approach to absconding by comparison with Rathgael's initiative, which had led to an immediate initial reduction in absconding, and we have observed that neither the Inspectorate nor the NIO gave a lead in urging St Patrick's to address the problem. SPT 81's death sadly underlines our earlier findings of systemic failure. Until the Inspectors' report identified the action needed in its 23 recommendations, no comment had been made about the extent of absconding and the risks it posed, either in inspection reports or on receipt of the regular statistical returns.

Slemish House

151 As St Patrick's was redeveloped, smaller units on a more domestic scale were built with specific purposes in mind. Slemish House was originally used to prepare senior boys for discharge. SPT 2 worked in Slemish House for ten years.[164] He said that it was his idea to use the unit to provide intensive care and security, as there was concern about the number of boys absconding and about the consequent need to transfer some of them to secure establishments such as Lisnevin and Hydebank. This was particularly unfortunate when boys with no history of offending began to offend while absconding and left St Patrick's with a criminal record, and SPT 2 felt that such transfers were unhelpful and unnecessary. Having

161 SPT 12833-12834.
162 SPT 1690.
163 SPT 12712.
164 Day 143, p.93.

been promoted to the post of Deputy Head, he took a demotion to establish Slemish House's new role.[165]

152 It was therefore decided (in the late 1980s, though the date is unclear) to open Slemish House as an eight-place unit to hold and contain boys while their futures were planned. This meant:

> "... not just physical containment of a body but, perhaps as important, emotional containment, i.e. making the boy feel safe and secure in the knowledge that adults (staff) are capable of exercising control over aspects of his life which, invariably, the boy will not have been coping with either in the community or in previous placements."[166]

It was felt to be:

> "...both damaging and frightening for the child who has not acquired self control to feel out of control."[167]

It was argued that:

> "external control of the boys should primarily be exercised by staff and not the building."[168]

153 A draft of the Slemish House *Staff Handbook and Guidelines* appears to have been written prior to the opening of the unit. It laid out the philosophy of the House, its role, guidelines for admission, the staffing, specialist support, the quality of life in the unit, security and physical controls, the management of children, meetings, education, medical provision, record-keeping, visits, daily routines and rules for the boys. It demonstrated comprehensive planning of the way the unit would be run, and indicated a consistent and coherent approach to the management of difficult behaviour at critical times.[169] The guidelines were intended for a wide range of readerships - primarily the staff working in the unit, but also the boys themselves, their parents and other agencies, and some sections, such as the rules for boys, were directed at particular audiences.

154 SPT 2 said that he had been unimpressed by the secure units he had visited in England and Scotland, as they offered no comfort.[170] Although admissions to Slemish House were made at a time of crisis and were short-term, SPT

165 Day 143, p.39.
166 SPT 18312.
167 SPT 18312.
168 SPT 18312.
169 SPT 18304-18352.
170 Day 143, p.41.

2 wanted boys to be able to settle down.[171] Placement in Slemish House was not intended to be punitive and was to be used only if there were no alternative.[172] Boys could not be admitted direct to Slemish House and those placed there had to have a history of absconding and to be at risk of injuring themselves or others if they were not admitted.[173] An impressive Admissions Panel of nine people was to decide all admissions other than emergencies, including members of the Board of Management, the Social Work Inspectorate and the Adolescent Psychology Research Unit.[174] In an emergency the Director or his Deputy were authorised to approve admissions, but such admissions had to be reviewed every 24 hours.[175] It seems that in practice these guidelines were not always followed.

155 In their report on the death of SPT 81 the Inspectorate were critical of the use of Slemish House as a response to misbehaviour. On his first night in Aisling House SPT 81, who was then aged 11, was playing up and using "spicy language" to the Night Supervisor, and he was placed in Slemish House. The Inspectors recommended that the use of secure accommodation in this way should be reviewed[176] and went on to recommend to the Northern Ireland Office that it should issue guidance on the use of secure accommodation in view of the lack of any regulations or guidance.[177] They appear to have overlooked the facts that SPT 81's placement in Slemish House had breached the school's own guidance and was contrary to the Training School Rules, 39 (d) (i) which stated that "No boy or girl under the age of twelve shall be kept in separation."[178]

156 Slemish House was seen as part of a continuum of care, with boys returning to open units as soon as it was feasible. Links were to be maintained, therefore, with the boys' keyworkers from the houses in which they had previously lived.[179] It was anticipated that placement in Slemish House would be short-term, with:

> "a gradual decrease of external controls as part of the boy's growth process and a staged return to greater freedom…".[180]

171 Day 143, p.45.
172 SPT 18314.
173 SPT 18315.
174 SPT 18316.
175 SPT 18316.
176 SPT 12640.
177 SPT 12641.
178 SPT 100511.
179 SPT 18315.
180 SPT 18313.

157 A straightforward points system was devised, different from that in the main school, and it essentially rewarded good behaviour and penalised misbehaviour. In practice, four levels were identified - green for boys doing well, amber for those with moderate problem behaviour, red for those presenting serious difficulties, and black for the most serious. Boys achieving green were returned to the units from which they had been admitted, though HIA 253 complained that he was continually knocked back.[181] The levels were decided at meetings of the full staff team held on Thursdays, and the boys were informed of the results soon afterwards.[182]

158 Boys faced with this system would have known where they stood, and for some boys going through unsettled phases this would have provided security. For those who were going through a seriously disturbed phase, however, points systems could have been irrelevant and the primary task would have been to use professional judgement to match the approach to the individual boy's needs. While the overall aims of Slemish House indicated an understanding of this type of need, the proposed working methods described in the handbook impress as being at times somewhat inflexible and mechanistic.[183]

159 Stringent requirements were laid down to limit the containment of boys in single locked rooms.[184] While arguing that physical restraint should only be used in crises, the guidelines made it clear that:

> "Staff who show fear of this physical restraint may be regarded by the boys as 'fair game'."[185]

Confrontation was seen as "not always avoidable" and confronting boys with their behaviour, describing their actions calmly, was advocated as it helped boys realise that they were not being blindly picked on or criticised.[186]

160 Detailed guidance was provided on visits, searching for contraband, the management of keys, the opening of mail in the presence of staff, the use of phones, smoking, the checking of cutlery and prohibited articles.[187] Advice on behaviour management encouraged lining up, calling the group together, phase completion, setting expectations, individual instruction,

181 Day 142, p.79.
182 Day 143, p.34.
183 SPT 18319-18320, 18328-18329.
184 SPT 18324-18325.
185 SPT 18325.
186 SPT 18330.
187 SPT 18326-18329.

tone setting, diversionary tactics, counselling, isolating boys, observation and the use of humour.[188] Fifteen types of records were to be maintained on boys' clothing and personal property, daily occurrences, medical provision, visiting, absconding, untoward incidents, the use of lock-up rooms, rewards and cash, searches, fire drills, cutlery checks, occurrences at night, the issue of keys, staff attendance and weekly meetings. Each boy was also to have a daily occurrence clipboard.[189] The daily routine was laid out in detail,[190] and the guidance ended with two pages of rules for boys[191] and a list of twenty-one rights of boys to food, clothing, comfortable accommodation, reviews, education, medical care, safety, access to legal representation, uncensored mail, access to a phone, privacy, access to a social worker, use of a complaints procedure, protection from solitary confinement, access to family and friends when appropriate, diet, companionship, exercise and fresh air, smoking (if over 16), personal possessions, reasons and explanations for plans and decisions, access to personal information and retaining identity and religious beliefs.[192]

161 The advice constituted a blend of common sense and acceptable professional practice, intended to maintain a calm atmosphere in a unit designed to cope with crises and challenging behaviour. One value of such guidelines is that they provide a template for good practice, against which events could be evaluated. How the guidelines were interpreted and implemented in practice could well have been different from the model laid out, as the evidence of witnesses demonstrated.

162 The handbook quoted Professor Masud Hoghughi:

> "In the Secure Unit the staff are the fulcrum around which everything rotates for the child."[193]

When Slemish House was opened, the staff team was drawn from the existing staff at St Patrick's and three of them gave evidence to the Inquiry. They faced allegations, which are dealt with elsewhere in this chapter, but overall they impressed as competent professionals who remained in post at St Patrick's for many years and delivered an acceptable quality of service in a very demanding field of work.

188 SPT 18334-18339.
189 SPT 18344.
190 SPT 18347-18352.
191 SPT 18353-18354.
192 SPT 18355.
193 SPT 18320.

Aisling House

163 This house was opened in May 1994 as a reception and assessment unit to accommodate 11 'care' boys. It was described by Inspectors as having "a fairly domestic atmosphere" and included offices, a recreation room, dining room, kitchen and single bedrooms for the boys. It had five external doors, and the Inspectors who investigated the death of SPT 81 were concerned that consideration should be given to fitting the doors with alarms so that staff were aware when they were opened. Some doors were locked, but this was more "to prevent the boys gaining access to some rooms rather than to stop them leaving the buildings."[194]

164 Boys admitted to the unit were initially subject to Place of Safety Orders, which lasted a maximum of 35 days. If it was felt necessary to hold a boy longer, an Interim Order for Detention was sought; this too lasted 35 days and one further consecutive Interim Order could be sought. A boy could therefore be held for a maximum of 15 weeks. By that time a decision should have been made on a long-term care plan, and if a longer period at St Patrick's was deemed to be in his best interests a Training School Order had to be sought.[195] This system resulted in a considerable amount of movement between St Patrick's and the courts. In the earlier years the police transported the boys to and fro, but during the Troubles the police were unable to undertake the work without excessive safety precautions, and so the staff conveyed the boys to court.

165 A boy admitted to Aisling House for assessment was allocated a keyworker. The Inspectors observed:

> "The keyworker takes a particular interest in the boy during his stay. These responsibilities include the basic tasks such as checking that he had adequate clothing and ensuring that he has an adult in whom he can confide. ...The keyworker role also entails taking the lead in the assessment process. The keyworker attempts to get to know the child both as a member of the group and during one to one sessions which are held once a week. ...Brief reports are written on these sessions..."[196]

Typically residential social workers were keyworkers for three or four boys.

194 SPT 12637.
195 SPT 12637.
196 SPT 12638.

166 The Inspectors examining SPT 81's death recommended that there should be "a more structured approach" to the assessment process, for example by using a Problem Profile Analysis. Although there were recordings of events which had occurred, "Few conclusions were drawn from them."[197]

167 Aisling House had two secure lockable rooms, known as "quiet rooms", furnished only with a mattress and a soft upholstered cube. In 1994 the Inspectors noted that the rooms had been used 92 times in the twelve month period from May 1994 to May 1995, but they expressed concern, as confinement in these rooms had been "on occasions as a response to quite minor misbehaviour", involving "disturbed children ... as young as ten years of age", though no ten-year-olds had been admitted to St Patrick's in 1994. They recommended that children should be removed to their bedrooms, accompanied by staff, who should remain with them.[198] In their review of the circumstances surrounding SPT 81's death, the Inspectorate described some of the practices concerning the separation of children as "unacceptable" and recommended a review of the use of secure accommodation.[199] They failed to observe that under the Training School Rules no child under twelve should have been confined in locked accommodation.

168 **We consider that the frequency with which the secure rooms were used and their use for young children, contrary to the Training School Rules, amounted to systemic abuse on the part of St Patrick's and by the SSI in failing to address this breach of the Rules.**

Discharge and Aftercare

169 Under Rule 47 of the Training School Rules the Board of Management was required to make "every effort" to obtain suitable employment and, where their homes were unsatisfactory, accommodation for young people on leaving. Rule 48 required Boards of Management to provide "a sufficient outfit" and "a reasonable sum for travelling and subsistence". Rule 49 required Boards to make arrangements for aftercare until the statutory period of supervision expired and to appoint aftercare officers. St Patrick's appears to have fulfilled these requirements, although, as in other homes we have considered, discharge came as something of a sudden shock to some boys. HIA 100, for example, considered the aftercare he

197 SPT 12639.
198 SPT 12640.
199 SPT 12640.

experienced in 1966 as 'risible'.[200] At any one time, therefore, St Patrick's was responsible for its resident population and a substantial number of boys on after care; at one time, for example, this amounted to 160 residents and 40 on aftercare, making 200 in all.

170 As in other homes, about half of the witnesses had problems in adult life with alcohol and/or drug-taking, about half suffered depression or other forms of mental ill-health, and about a third had problems concerning relationships with partners and children. About two-thirds had had lengthy prison records as adults. These figures are inevitably imprecise as they are based on self-reporting, and we are unable to tell whether they represent St Patrick's clientele as a whole. Since the boys admitted for 'justice' reasons often already had substantial offending records, and since for some these were augmented because of involvement in the Troubles, it might be considered unsurprising that they continued in adult life with patterns of behaviour established when they were juveniles. It is significant, though, that for such people St Patrick's may have contained their behaviour while they were resident but it failed to break their patterns of offending and to help them to adopt and internalise less antisocial values as adults.

171 This failure was, however, shared with other similar schools in the United Kingdom. In England and Wales, 'success' was judged by the number of children found guilty of offences in the two years following discharge, and the so-called 'success rate' was just over 30%. Dissatisfaction with this statistic was one of the factors which led to the closure of most of these schools in England and Wales during the 1970s; by contrast, St Patrick's remained active, though serving dwindling numbers, till the end of the training school system in 1996.

Staffing

172 Over the period covered by the Inquiry the pattern of staffing changed considerably in four main ways:

(a) In the early years staffing levels were low. The Castle Priory Report guidelines, which were published in 1968, were adopted and applied to St Patrick's, and they formed the basis for the staffing establishment until the 1990s.[201] Though the internal inquiry undertaken by two members of the St Patrick's Board felt that staffing levels were adequate,[202]

200 Day 138, p.125.
201 SPT 12826.
202 SPT 12902

these levels were criticised by the Social Services Inspectorate as being insufficient when they examined the circumstances surrounding SPT 81's death in 1994, and they recommended an increase.[203]

(b) The balance between brothers and lay staff also changed. St Patrick's may have been staffed entirely by brothers in its early history, but HIA 314, who was admitted to St Patrick's in 1959, mentions lay staff, and they appear to have been appointed increasingly from about 1970 onwards, as demonstrated in the people who were witnesses. According to SPT 52, more lay staff were appointed during the Troubles, and the staffing establishment was doubled.[204] By the end of the Inquiry's remit very few of the staff were brothers.

(c) In the 1980s there was a concerted effort to improve the level of training, both at qualifying level and in-service, at St Patrick's. A work-based qualifying programme was established in conjunction with Rupert Stanley College (later Belfast Metropolitan College) and a total of 29 staff obtained social care qualifications. A staff team which was largely unqualified in the 1970s was converted into a mainly qualified team by the early 1990s, which was commendable.[205]

(d) Although there were two nuns providing health care, the staff was predominantly male until the mid-1970s when women began to be appointed. This was in accordance with standard practice at that time, as it was felt that staff teams in residential child care should include both men and women, both as role models and to provide complementary types of care.

173 One remarkable feature of the staff at St Patrick's – both brothers and lay staff – was the length of time that they remained in post. BR 26 commenced work at the Milltown site on 1 September 1951 and worked there for six years before the school moved to Glen Road, where he remained until 1995, a total of 44 years' work at St Patrick's. BR 94 was in post from 1961 to 1997, amounting to 36 years and BR 50 was there from 1977 to 1996, or 19 years. The longest serving member of lay staff was SPT 2 who worked at St Patrick's for 30 years from 1966 to 1996. SPT 53 was probably in post for 28 years from 1966 to 1994. SPT 3 was there for 26 years from 1973 to 1999. SPT 52 (worked at St Patrick's for 29 years from 1967 to 1996.[206] SPT 40 was there for 22 years from 1975 to 1997. SPT 26 joined the staff in 1972 and 43 years later he is

203 SPT 12826-7
204 Day 144, p.61.
205 Day 145, p.110.
206 SPT 2902.

still working on the site as the Principal of Glenmona. These eight staff, who all gave evidence, contributed over 270 years' service between them.

174 Clearly, as the numbers of staff increased in later years, there were many who must have served for shorter periods, but this core of long-serving staff will have provided valuable continuity, stability and consistency of practice. Consistent teamwork is a key feature of good residential care practice, and if staff work together over a long period they get to know each others' ways of working. The fact that they remained together suggests that they were at least content to continue in post at St Patrick's and at best that there was good teamwork. With consistent standards, boys would have been secure in knowing where they stood and what was expected of them, and staff would have known that they were being supported by their colleagues. BR 26 stated that the reason why they stayed was that they were totally committed to the work and some said that their time working at the school had been the happiest years of their working lives.[207] BR 26 himself said that he would choose to work there all over again.[208]

175 SPT 2 joined the staff part-time in 1966 to assist with activities. He became a full-time worker in 1970, undertook the Certificate in the Residential Care of Children and Young People in 1972-3 and retired in 1996 after 26 years' service. When he started, there was only one member of staff on duty at any one time in the senior school and one in the junior school, each supervising four dormitories with up to 80 boys in all.[209]

176 Staffing levels were progressively improved. When investigating the death of SPT 81 in 1994, the Inspectors considered the levels of staffing at St Patrick's. They found a ratio of 1:2 in Slemish House, 1:3.5 in Aisling and 1:4 in the other units. The Northern Ireland Office grant to St Patrick's had allowed for 7.5 staff in Aisling House but only 6 were appointed, and they recommended that Aisling House should be:

> "at least staffed to the levels allowed for in the funding provided by the Northern Ireland Office."[210]

177 However, the Inspectors also considered the additional demands made on staff by the nature of the work in Aisling House; they concluded that more than eleven staff were needed, and recommended that the funding supplied by the NIO should be reviewed.[211] The Inspectors went on to

207 Day 157, p.45.
208 Day 157, p.118.
209 Day 143, p.30.
210 SPT 12643.
211 SPT 12644.

consider the staffing of other units, the availability of the Team Managers and the need to have a senior member of staff on site at all times.[212] It is clear from the Inspectors' conclusions that if requests had been made for additional staff, the Order would have been pushing on an open door. In practice they had not even filled all the posts on the establishment for which they were receiving funding, and staff were stretched, to judge by the overtime worked and the allocation of staff from other units to fill gaps. Indeed, staffing was particularly thin at the time of the absconding, as explained in the SSI review, and eight of the SSI's 23 recommendations for action related to staffing.[213] As the absconders were unsupervised at the time of their departure, it could be argued that the shortage of staff on duty may have contributed to the failure to prevent the absconding in which SPT 81 was killed.[214]

178 **The failure to appoint sufficient staff amounts to poor management, and we consider it to be a systemic failure.**

179 Brother Stephen joined St Patrick's on 1 October 1940 as a Prefect (the Order's term for a residential child care worker) and was Brother Director from 1942 up to his death on 22 December 1969. From 1942 to 1960 he was also the school Principal. His contribution was outstanding: he oversaw the redevelopment of the school on the Glen Road site and was the leading influence in the development of Rubane. He not only oversaw the management of the school for 27 years, but he also demonstrated a capacity for working with church leaders, civil servants and politicians, and he played a role in the planning of child care services throughout the province as a member of the Child Welfare Council. He was invested with the OBE on 3 March 1966.[215]

180 The lay staff mostly commuted to St Patrick's from various parts of Belfast, though some staff housing was provided on Glen Road and attached to the chalets. The brothers, however, lived on site in a community house. There they were accountable to a brother who acted as Community Director who oversaw their devotional life, managed the community's budget and supervised them as brothers.[216]

212 SPT 12644-12646.
213 SPT 12834.
214 SPT 12812.
215 SPT 232-258.
216 Day 157, p.111.

181 For much of its existence, St Patrick's had a full-time Chaplain, but in later years this post became part-time.[217]

Inspections

182 It appears that inspections were carried out annually by the Ministry of Home Affairs while St Patrick's was an industrial school and reformatory, though there are no surviving records of inspections prior to 1950. When it was redesignated a training school, following the 1950 Act, inspections were still undertaken by the Inspectorate of the Ministry of Home Affairs.

183 An inspection report by Miss Kathleen Forrest and Dr Simpson on 29 November 1950 made reference to earlier inspections. There was mention of the introduction of standardised medical records and the trialling of the bell and pad system for treating enuresis. There was also reference to trade training. Overall, the inspection approved of St Patrick's work and it was described as "an excellent institution with a cheerful homely atmosphere."[218]

184 A further approving report recorded an inspection on 18 November 1951.[219] Throughout the 1950s there are references in the home's diary to annual visits of inspection, and these entries are countersigned by the inspectors, but no reports have survived. Most of the visits were conducted in one day by two people, but in 1960 the inspection took a week and in 1971 it took two days.[220] During the 1950s and 1960s the log indicates that a number of distinguished visitors called on St Patrick's, including successive Lord Mayors of Belfast, Lord Wakehurst, Rt Hon Brian Faulkner, Lord Erskine, the Attorney General, the Lord Chief Justice, the Permanent Secretary of MOHA and a number of MPs.[221] [222]

185 There is a reference in the St Patrick's diary to an inspection on 15 June 1971, but none thereafter until 1988. There is also a major gap in the inspection records. This may in part be due to the systematic destruction

217 Day 157, p.111.
218 SPT 10384 –10386.
219 SPT 10393-10394.
220 SPT 10466, 10496.
221 Inspection visits: 28 January 1953, Miss Miller (SPT 10446); 26 October 1954, Dr Simpson and Miss Forrest (SPT 10452); 29 November 1955, Dr Simpson and Miss Knight (SPT 10455); 30 November 1956, Dr Simpson and Miss Forrest (SPT 10456); 3 December 1957, Dr Simpson and Miss Forrest (SPT 10460); 9 December 1958, Dr Simpson and Miss Forrest (SPT 10462); 8-15 December 1960, Dr Simpson and Miss Forrest (SPT 10466); 11 December 1962, Dr Simpson and Miss Forrest (SPT 10470); 8 March 1966, Miss Forrest, Mr Blackburn and Mr Westhead (SPT 10482); 22 August 1967, Dr Simpson and Miss Forrest (SPT 10488); 15-16 June 1971 (SPT 10496).
222 SPT 10446-10496.

of records, as no reports are available between 1951 and 1988, but it may also reflect a reduction in the number of inspections and the style of inspecting. The Social Work Advisory Group was made responsible for inspections from 1972 onwards, and, as for children's homes, their visits were not regular and tended to be supportive, advisory and informal, rather than inspectorial. We noted Mr Donnell's evidence that he visited the training schools about once a month, and sometimes more frequently, and was used by the principals as a sounding board to discuss practice and procedures.[223] We accept that this contact provided some degree of external scrutiny to the school.

186 We have noted in other modules the failure of the Social Work Advisory Group to conduct regular formal inspections from the early 1970s to the late 1980s, when they were increased in response to the Kincora scandal prior to the publication of the Hughes Report. **St Patrick's was not inspected between 1971 and 1988, and we consider the lack of formal inspections a systemic failing.**

187 However, following the publication of the Hughes Report in December 1985 it was decided to inspect all residential child care facilities. Between May 1987 and April 1988 all four training schools were inspected. The inspection of St Patrick's took place in February 1988.[224] There were at that time 91 boys on roll, but only 61 in residence; there were 73 staff, including 35 care staff, 7 night care staff and 16 teachers.[225] The school was therefore sufficiently staffed for boys to receive individual attention; indeed, there were very few allegations relating to St Patrick's last decade as a training school. The main report was 69 pages long and contained 52 recommendations, though there were no suggestions as to which should be treated as priorities. The overall conclusion was that the quality of care at St Patrick's was good.

188 In October 1989 the reports on the training schools were issued as a compendium.[226] There was, however, a sequel to this inspection, described in the next paragraph. At this time it was the policy that major inspections should take place every four years, with annual 'regulatory' inspections carried out by individual inspectors to check on progress in the implementation of recommendations made in the main inspections. In these inspections Inspectors toured the school and then spent time with the Principal.[227]

223 SPT 3005.
224 SPT 18358-18342.
225 SPT 18364.
226 SPT 16222-16304 and appendices SPT 16305-16310.
227 Day 157, p.64.

189 Relations between the School and the Inspectorate were for the most part cordial, but there was one such follow-up inspection on 24 January 1990 which caused considerable tension. On 12 March 1990 A.D. Shannon, newly arrived in the Northern Ireland Office to take over the division which included responsibility for the training schools, wrote a terse letter to the Bishop as Chairman of the Management Committee, expressing concern at the school's failure to implement the recommendations of the 1988 report, citing poor morale, low standards of care and poor physical standards. He said that he would have to advise the social services boards not to send children to St Patrick's if emergency action were not taken.[228]

190 This letter caused considerable alarm, as it was the first time that an inspection had led to such severe criticism, and there had been no forewarning that there was such concern. At meetings of the Board of Management on 23 March and 27 April 1990 concern was expressed at the change of language between the Inspectorate's reports and Mr Shannon's letter. Mr W.P.M. O'Driscoll, a Solicitor and Board member, responded in detail, essentially stating that action was being taken on all twenty of the recommendations within the control of the school, but that other issues, such as the physical condition of the buildings, were dependent upon capital funding from the government.[229] Eventually £1.9 million was provided to update the units. No allegations of abuse have been made concerning this period, but the contretemps was significant in that St Patrick's had till then always maintained good relations with the government and had come out of inspections well.

191 In December 1993 there was a further regulatory inspection. At that time there were 98 boys on the roll but only 43 were present. Fourteen of the boys present under Training School Orders were there because of truancy. There were 61 staff on the establishment. New units were being built. The Inspector's report contained only two recommendations.[230]

192 Finally, there were unannounced inspections, designed to check that the standards established in the formal inspections were being maintained at other times, and for this purpose Inspectors called at weekends and in evenings. Indeed, BR 26 described one Inspector as part of the furniture, as he visited frequently.[231] The visits of Inspectors were welcomed for the most part, as their advice was "invariably helpful".[232]

228 SPT 10420-10423.
229 SPT 10424-10435.
230 SPT 10410-SPT 10418.
231 Day 157, p.65.
232 Day 157, p.64.

Allegations of Abuse

Overview

193 A total of 27 witnesses made allegations of sexual or physical abuse against 26 brothers, 1 priest and 11 lay staff, or 38 adults in total. The periods to which these allegations relate were:

Year	Number of Applicants	Boys on Roll
1950s	1	150-200
1960s	6	200-250
1970s	12	160-190
1980s	6	60-95
1990s	2	43

194 Of these 27, eleven made allegations of both physical and sexual abuse, eleven alleged sexual abuse only and five alleged physical abuse only. One allegation specifying emotional abuse was made. There were no substantial allegations of neglect. It will be noted that the peak of the allegations was in the 1970s, and that the numbers fell away thereafter. The majority of the allegations were made against the De La Salle brothers, rather than the lay staff. There were two or three years when a high number of allegations were made, but there were other periods when no allegations were made for some years. In particular, there were very few allegations made concerning the last decade of St Patrick's role as a training school; the occupancy of the school also reduced at this time.

195 There were two brothers and one lay member of staff who were the subject of eight or more allegations, and they accounted for about a third of the allegations. By contrast, 29 of the 38 adults were subject to three or fewer allegations, and there were many more staff who were not subject to any allegations.

196 The number of allegations relating to St Patrick's period as a training school has to be set in the context of a 45-year period when for much of the time there were up to 160 boys in the school and some thousands of boys will have passed through St Patrick's. It should be noted that while the De La Salle Order offered a general apology to all victims of abuse in St Patrick's, with minor exceptions individual witnesses accused of abuse and the Order collectively denied every allegation of abuse other than those perpetrated by DL 137.

197 In this section of the chapter, allegations of sexual abuse are considered first and are listed by the decade in which it was said to have taken place, except that the two brothers and one member of lay staff who were subject to the most allegations are then considered in turn. Peer sexual abuse is then considered. Allegations of physical abuse are divided into those concerning staff and those relating to peers. Finally, allegations concerning other types of abuse and unacceptable practices (other than punishments, which have been described above) are addressed.

Allegations of Sexual Abuse: 1940s

198 In 2004 SPT 101 alleged through a solicitor that in late 1943 and early 1944 he had been seriously sexually and physically abused by BR 97 while based at Forkill, when St Patrick's leased additional premises there between 1941 and 1944. He believed that at least two other residents had been abused by the same brother, and the matter was investigated at the time by BR 39.[233] BR 97 was transferred to another school in 1945, and left the Order in 1947.[234] SPT 101 was also seriously upset by absconders having their heads shaved and by the death of a boy who fell off a tractor on his way to work in the potato fields.[235]

199 At the request of the Minister of Home Affairs, Rt. Hon. Edmond Warnock KC, on 9 April 1948 there was an inquiry presided over by the Bishop of Down and Connor, Dr Mageean, into abuse in 1946 and 1948.[236] BR 39, then the Superior, described some of the boys as "sex maniacs" and dismissed their allegations of sexual abuse by brothers, including BR 69, who was accused by three boys. They had said to him that they had been put up to make the allegations by an older boy who, on being questioned, said that he found BR 69 too strict and wanted him moved. Allegations had also been made against BR 86, BR 83 and BR 70. SPT 32 also made allegations against BR 70, but again BR 39 dismissed his evidence as that of a sex maniac. It was also alleged that SPT 33, a lay woodwork teacher, had painted five boys' privates, but BR 39 had not wanted "to go into it with this man" and so dismissed him.[237] Bishop Mageean wrote to the Minister of Home Affairs on 29 April 1948 to say that there was no foundation to the allegations against the brothers, but

233 SPT 30101-30103, 30119-30120.
234 SPT 30104.
235 SPT 30121.
236 SPT 10578-10579.
237 SPT 10551-10554.

that SPT 33 had been dismissed.[238] In oral evidence to the Inquiry, HIA 272 reported that SPT 43 said that he had had sex with BR 86. He taught at St Patrick's for 49 years up to 1992.[239]

Allegations of Sexual Abuse: 1950s

200 SPT 131 alleged indecent assault by BR 43 during the 1950s. At this time St Patrick's was sited at Milltown. No other allegations of sexual abuse were made against BR 43, but there was one allegation of physical abuse. The police investigated SPT 131's allegation in 1993 and again in 2005 but decided to take no action.[240] SPT 131 did not come forward as an applicant. We conclude that sexual abuse was not a systemic problem during the 1950s.

Allegations of Sexual Abuse: 1960s

201 The School moved to Glen Road in 1957, and further allegations relate to the period soon afterwards. HIA 314 stated that he was admitted to Milltown, but was one of the boys moved to Glen Road when it opened, though the records suggest that he was in fact only admitted on 10 June 1959, and would never have been at Milltown. He made a number of allegations of both sexual and physical abuse, and named four brothers who he said abused him – BR 1, BR 39, BR 42 and BR 47.[241] These brothers are all deceased except for BR 42, who denied all of HIA 314's allegations.

202 HIA 314 stated that brothers checked them under their arms and between their legs in the showers and, as noted above, helped the "younger" boys into their pyjamas. There were very few boys who were not teenagers, and there were no very young children who might have required such help. BR 42 and BR 47 put their hands under his sheets and fondled him, and he was:

> "often woken in the middle of the night to perform sexual acts on the Brother who was on duty that night".[242]

BR 39 took a "special interest" in him, and took him out to restaurants and hotels for meals.

> "Looking back now, it is obvious they were grooming us and that [BR 39's] touching was not accidental but sexual in nature".

238 SPT 10578-10579.
239 Day 139, p.85.
240 SPT 26829-26830.
241 SPT 003-004.
242 SPT 003.

He caressed HIA 314's penis, legs and bottom and forced him to engage in mutual masturbation. The boys wore shorts and brothers put their hands up the boys' legs to fondle them. At the holiday home in Cushendall, there was woodland, and:

> "... you would often see [BR 47 and BR 26] disappearing with the boys but nothing was ever said about it".[243]

203 HIA 100 said that BR 94 used to pull him against his penis, but he did not see this as sexual abuse.[244] He said the brothers abused him at the swimming pool, in the store and in the brothers' house, where he was taken by a brother, as it was out of bounds to boys.[245]

204 HIA 314 described a pattern of sexual abuse also reported by witnesses who were resident in Rubane, which was also run by the De La Salle Brothers:

> "[BR 47 and BR 42] sexually abused me regularly. They would make me sit next to them in the back row of the television room and fondle me. They would open their cassocks and make me masturbate them and then they would masturbate me. [BR 1] was doing this too. There would be a number of Brothers sitting in the back row with a number of boys beside them. I saw other boys being abused in the television room. [BR 48] used to sit at the back watching television with younger boys. He always had their hands in the pocket of his cassock. He had a certain group he always chose. Nobody was allowed to sit in the back row unless the Brothers said they could. They all had their favourites."[246]

205 A significant feature of this allegation is that, if it is true that a number of brothers were involved, it is hard to imagine that they were not well aware of each others' misconduct. If so, this suggests that there was a general culture among some brothers that sexual abuse of boys was acceptable, and it is reasonable to suppose that they could have felt that this gave them licence for more serious sexual offending in private.

206 SPT 40 was a member of the care staff throughout the 1960s, and in oral evidence he expressed concern that the brothers sat with their arms round boys in the TV room. He felt it was wrong and it made him feel "very, very uncomfortable", and he would "glare" at the brothers, but while the

243 SPT 004.
244 Day 138, p.141.
245 Day 138, p.142.
246 SPT 004.

lay staff were aware of this practice, they felt unable to do anything about it.[247]

207 HIA 314 also alleged that brothers were involved in abusing boys in the changing room for the swimming pool, involving mutual masturbation, and in the dormitories and the brothers' cells. He said he never let it get as far as intercourse, but he knew other boys who did.[248] BR 42 denied the possibility of abuse in the dormitories, as there was a night supervisor.[249]

208 HIA 272 said that he distinctly remembered brothers holding the hands of younger boys and letting them have treats and cigarettes.[250] The Order denied any collective memory of brothers holding boys' hands, though they would have comforted children who were upset. They sometimes bought sweets or cigarettes for boys as acts of kindness.[251] [252] In view of the age at which boys were typically admitted, 'younger boys' would presumably have been twelve-year-olds.

209 HIA 262 was only in St Patrick's briefly in 1964, before being moved to Rubane. He alleges that he was abused in the classroom by BR 24, who first made as if to comfort him, but then put his hand down HIA 262's trousers and fondled him, before making HIA 262 fondle him in turn. HIA 262 told us that when he tried to escape, he was apprehended, beaten, slapped across the face, put in a windowless store room for some time by BR 24, and then told to tell no one.[253]

210 Five other former boys at St Patrick's approached the police with allegations against BR 24, although none of them applied to give evidence to the Inquiry. Their allegations included stroking, reciprocal fondling, masturbation and rape. BR 24 died in 1976 and was therefore unable to respond to these allegations.[254] The Order has pointed out that the police "dismissed as fabrication the allegations of two of the complainants".

211 HIA 100 alleged that BR 47 sexually abused him in the brother's room off the dormitory, making him perform oral sex or masturbation, or having penetrative sex.

247 Day 145, p.11.
248 SPT 005.
249 SPT 25510.
250 SPT 082.
251 SPT 323-324.
252 Day 139, p.86.
253 SPT 028.
254 SPT 20808, 22545, 22554, 20837-20843, 25378-25379

> "These incidents happened regularly, monthly or sometimes more frequently".[255]

Allegations of Sexual Abuse: 1970s

212 HIA 58 said that on two occasions when he was placed in a sick room on the second floor, where there was no light except from a frosted window and the furnishings consisted of a mattress and an army blanket, he was physically and sexually assaulted. On each occasion two brothers held him down, as he was kicking out, and a third raped him anally; on the first time the abuser was alleged to be BR 1 and on the second possibly BR 94. HIA 58 said that this lasted about ten minutes, and that the brothers then left him:

> "You would get a glass of milk and a jam sandwich next morning".[256]

213 HIA 272 alleges that he had been sexually abused by BR 5 at primary school before admission to St Patrick's.[257] HIA 272 was admitted to St Patrick's about 1970, by which time BR 5 had been appointed head of the school, and HIA 272 alleges that, on the pretext of counting the money in the charity boxes or to punish him, BR 5 used to take him into his office, lock the mahogany door, close the blinds and sexually abuse him. HIA 272 described the way that sweat poured down BR 5's face when he had abused him; the abuse was said to be fairly regular over a period of about a year.[258] HIA 272 said that when he objected, BR 5 threatened to send him to a home where he would be raped.[259]

214 HIA 272 noted that the "country boys" did not get visitors or home visits (as the buses had been hijacked and burnt out during the Troubles), and the brothers befriended them, giving them treats and cigarettes, walking around holding their hands, and receiving sexual favours in return.[260] Furthermore, HIA 26 said that he kept seeing brothers from Rubane, where he had been sexually abused, and he was afraid of them.[261]

215 HIA 162 was admitted to St Patrick's in 1973. He made minor allegations of sexual abuse concerning the staff:

> "[The] woodwork teacher used to push up behind us as we bent over the lathe, and then laugh it off".[262]

255 SPT 049-050.
256 SPT 058-059.
257 SPT 078.
258 SPT 079.
259 SPT 080.
260 SPT 081-082
261 SPT 073.
262 SPT 107.

The brothers would also rub themselves against boys, he said, but he was not himself molested.

216 HIA 374 stayed at St Patrick's briefly in the mid-1970s, and alleges that he was sexually abused once by BR 89 who was at first very nice to him, stroking his hair and face but then forced HIA 374 to masturbate him over his clothing, which left HIA 374 "totally shocked" as he had "never experienced anything like that before".[263] This is the only allegation concerning BR 89.

217 HIA 227 said that BR 4:

> "frequently felt my backside through my trousers and he did this no matter where you met him or whether people were there as well. I saw him do this on numerous occasions to other boys."[264]

218 HIA 218 and his brother HIA 219 made serious allegations of sexual abuse by staff both at Rubane, where they had been prior to transfer to St Patrick's, and at St Patrick's itself. HIA 218 told us he woke to find another resident performing oral sex on him, he described a brother lying on his bed and masturbating, himself, and said he was touched in a sexual manner by the cook (presumably DL 137). Without providing substantiating evidence, he summarised:

> "We were sexually abused as frequently as every other night at St Patrick's. You had to perform oral and anal sex and masturbation on the Brothers".[265]

219 HIA 219 gave accounts of systematic grooming and escalating abuse by two brothers, to the point that:

> "...both brothers were coming in and buggering me on different nights".[266]

He also alleged abuse by another brother who was responsible for clothing, and by a civilian worker when they were on the home's annual holiday.[267] The allegations of HIA 218 and HIA 219 are among the most serious made against staff at St Patrick's, going well beyond the more typical complaints of fondling and masturbation. It should be noted that we have taken account of the credibility of witnesses and of the Order's observations in

263 SPT 120.
264 SPT 130.
265 SPT 136.
266 SPT 144-145.
267 SPT 146.

this respect, and in general we found the more extreme allegations less convincing.

220 HIA 96, who said that a woman touched him while hanging curtains. He told the head of Aisling House (SPT 13) who was disinclined to believe his allegation.[268] HIA 96 added that the same woman also touched other boys sexually, and he said that he saw another female member of staff in a boy's bed under the duvet.[269] These incidents were presumably among the few allegations relating to the 1980s.

221 The allegations listed above cover four decades, a period in which over a thousand boys will have passed through St Patrick's. The question facing the Inquiry is whether the allegations constitute systemic abuse, rather than a scatter of individual instances. In so far as some of the incidents described appear to be one-off and the only allegation against a specific brother or lay member of staff, it is not possible to describe all the alleged abuse as systemic.

222 We are satisfied that there was a pattern of sexual activity in the television room on the part of some brothers which amounted to systemic abuse. It was not only reported by witnesses, but a former member of staff expressed concern in his oral evidence about brothers' behaviour in the TV room. It also replicated practice described at Rubane, which was also run by the De La Salle Brothers. Some brothers must have been aware of each others' misconduct, and the evidence suggests that the sexual misconduct in the television room was only the most obvious symptom of a wider pattern of sexual abuse, particularly during the 1970s, some of which was relatively minor, but some of which was serious.

223 **We therefore consider the sexual abuse perpetrated by some Brothers, particularly as reported in the television room, to have been systemic.**

BR 1

224 BR 1 was at St Patrick's from 1958 to 1971, and from 1972 to 1977. At first he had the role of clerk, but in 1965 he became a housemaster. In 1977 he was moved to Rubane to act as Brother Director. At Rubane he was subject to a large number of allegations of sexual abuse, which appear to have consisted of stroking, rubbing and fondling, with no suggestion of any penetrative abuse. Bishop Philbin, as the Chairman of

268 Day 142, p.149
269 Day 142, p.152

the Board responsible for Rubane, learnt of the allegations and suspended him in 1980. The police investigated the allegations and BR 1 was to be prosecuted but he escaped court action on grounds of serious ill-health, retiring to the south of Ireland, where he lived for a further twenty years, dying in 2000. These matters are dealt with more fully in the chapter on Rubane House.

225 At St Patrick's BR 1 at first worked in the office as an administrator, and he was said to have had very little direct access to boys, other than the few specifically allocated to work in the office. Some witnesses said that they rarely saw him or that they saw him only during Mass. However, according to HIA 100, BR 1 was involved in boxing and did not confine himself to the office, being around the school a lot.[270] It was said, for example, that brothers passed through the junior school on the way from the offices to their house. His abuse of boys at St Patrick's was said to have started in 1957 and continued to 1971, covering most of his time in the school, but the number of boys alleging abuse is fewer than at Rubane, perhaps because of the limits on his access to boys. Allegations by HIA 314 and HIA 58 have already been quoted.

226 HIA 100 made allegations against BR 1:

> "[BR 1] was always touching you up and pulling you in towards him. He made me put my hand inside his long robe and masturbate him. This happened soon after I arrived at St Patrick's and it happened on at least a monthly basis. It often took place in the store outside the dormitory or near the swimming pool area or at the brother's house, as he would take you there on occasion".[271]

This statement is unusual in its reference to the brothers' house. Unless BR 1 chose times when all the other brothers were otherwise engaged, they would have been aware of this. HIA 100 alleged that the abuse took place three or four times a week, as BR 1 decided.

227 HIA 229 was at St Patrick's about the same time as HIA 314. He states that he was sexually abused by a number of brothers, but mainly by BR 1.[272] He repeated HIA 314's account of sexual abuse while watching television and in the cinema; BR 1 used to give him sweets then fondle him, though he tried to sit further away.

> "At the time I did not realise it was wrong because I was young and

270 Day 138, p.144.
271 SPT 049.
272 SPT 010.

impressionable although now I can see how wrong it was. At the time I was just having a hard time and felt very lonely".[273]

228 HIA 229 went on to allege that he was buggered by BR 1 on three occasions in an area known as the pigeon holes where boys used to hang up their suits and where they could not be seen from the dormitory. He also mentioned other times when BR 1 forced him to perform oral sex and masturbate him, when he sexually assaulted HIA 229 in the clothing store and when he was ill in bed, alone in the dormitory.[274] HIA 229 also alleged that when taken by car to help locate absconders, BR 46 drove and HIA 229 was in the back with BR 1 who made him masturbate him. Again, at Kilmore House in Glenariff, when preparing the house for the school's holidays, BR 1 buggered him, and a visiting brother from Dublin forced him to perform oral sex. HIA 229 believes he was targeted, selected to do the work at the holiday home so that he could be abused.[275] This pattern of abuse is different from that reported in Rubane and by other witnesses at St Patrick's, in that HIA 229 is the only witness to allege penetrative abuse by BR 1. The Order noted that three witnesses who alleged abuse by BR 1 were not at Rubane with him (though one was at St Patrick's at the same time as BR 1), and that during the 1993-4 police enquiries no complaints were made against BR 1 about his time at St Patrick's, but that the majority emerged after allegations had been made against him about his time in Rubane.

229 **Although the Order has stated that they do not see the allegations as well founded, it is our view that BR 1 sexually abused boys while he was at St Patrick's and that this constituted systemic abuse; if he had been apprehended and had not been promoted to be Brother Director of Rubane House, the boys whom he abused there would not have been abused by him.**

BR 26

230 Br 26 had a remarkable career at St Patrick's, having joined the staff at the age of 21 on 1 September 1951 when the school was based at the Milltown site and left in 1995 when he was appointed Brother Provincial of the De La Salle Order for the whole of Ireland. During the course of his career he was first a Housemaster, and later Head of the Senior School,

273 SPT 011.
274 SPT 011.
275 SPT 012.

Director of the Community and finally Principal, holding all these roles for several years. He therefore made a major contribution to the management and development of St Patrick's, and the insights he offered in his oral evidence to the Inquiry and his impressive recall of events despite having attained the age of 85 indicated some of his qualities as a professional. SPT 26, who worked at St Patrick's for many years and was Director of Glenmona Resource Centre, considered BR 26 "a very decent, caring considerate person".[276]

231 It is hard to square his evidence and BR 26's distinguished career record, therefore, with the fact that sixteen former residents at St Patrick's made allegations of physical and/or sexual abuse against him. Of these, six gave evidence to the Inquiry, whereas others had spoken to the police. These allegations related to events spread over many years from May 1963 to August 1995, and there is no obvious reason why BR 26 should have been selected as a target for allegations if they were false. All the allegations were denied by BR 26, who provided denials or rebuttals in each case.[277]

232 SPT 145 said that BR 26 was well liked and "hard but fair". He knew BR 26 from 1963 to 1965 and alleged that when he was first admitted to the school BR 26 punched him in the stomach, just to let him know who was boss and that he was not taking any nonsense.[278]

233 HIA 17 alleged that in the late 1960s he observed BR 26 having sex with a boy and that, when he told other boys, BR 26 maltreated him, attempting sexual abuse. He added that he told BR 83 who confronted BR 26.[279] BR 26 said that HIA 17 was in the junior school, whereas BR 26 was in the senior school and was not involved in the activities where the alleged abuse took place. HIA 58 alleged that BR 26 threw him in the swimming pool for absconding, beat him and hit him with a bunch of keys.[280] BR 26 said that he had a master key, not a bunch, and that HIA 58 was in the junior school.[281]

234 HIA 26 was admitted to St Patrick's in 1970. He states that when he was in a punishment cell BR 26 "felt all around me and tried to sexually assault

276 Day 145, p.87.
277 SPT 2191-2196.
278 SPT 21123.
279 SPT 25466.
280 SPT 057-058.
281 SPT 2193.

me there and I kicked the legs off him".[282] He was fifteen and a half by this time. HIA 137 described being punished by BR 26, whom he described as "the enforcer", belting him on a number of occasions, in order to break him, once after insisting on a prolonged cold shower first.[283] HIA 374 alleged sexual abuse, but it is unclear whether his description referred to BR 26.[284]

235 HIA 54 was in St Patrick's on two occasions but made an unusual allegation of sexual abuse, stating that he was under the influence of tranquillisers on his first admission in 1978, and that he was held down by two brothers while BR 26 raped him.[285] SPT 130 alleged repeated sexual abuse by three brothers in consort, including BR 26, in the dormitory under the pretence of delivering comics.[286] BR 26 said this was a total fabrication.[287] HIA 51 also alleged sexual abuse by BR 26 while delivering comics to his bedroom late at night.[288] While denying the allegation of abuse, BR 26 acknowledged that he delivered comics to boys twice a week to help them settle down.[289]

236 SPT 154 alleged that BR 26 took him out in his car and made advances. BR 26 said he did not recall him[290] but that he would not have taken this boy out because of his unreliability, though he did on occasions take boys out.[291] SPT 136 alleged that during the mid-1980s BR 26 abused him sexually while providing comics, involving oral sex.[292] SPT 136 was later convicted of perjury, having made a false allegation which resulted in a man being convicted.[293]

237 HIA 253 said that BR 26 groomed him by putting his arm round him, touching him non-sexually and suggesting that he might be able to make things easier for HIA 253, perhaps shortening the length of his stay at St Patrick's. Then BR 26 touched him, took him to a room, and tried to persuade HIA 253 to masturbate him, exposing himself on three or four occasions. HIA 253 resisted and from then onwards he attempted to abscond at every opportunity, which led to his transfer to Lisnevin.[294]

282 SPT 074.
283 SPT 25376-25377.
284 SPT 2196.
285 SPT 151.
286 SPT 26824-26825.
287 SPT 2196.
288 SPT 166.
289 SPT 2192.
290 SPT 2195.
291 SPT 22944.
292 SPT 2194.
293 SPT 20597.
294 SPT 173-174.

238 SPT 119 alleged that in the late 1980s BR 26 and two other brothers anally raped him while they were under the influence of drink when he was on his own in his unit, having been kept back while his unit was on holiday.[295] BR 26 said that he was a life-long teetotaller and that one boy would not be left on his own in a chalet.[296] HIA 384 alleged that SPT 54 was BR 26's "golden boy" and that BR 26 had paid SPT 54 to abuse him sexually while placed in Slemish House. BR 26 considered this allegation "totally ridiculous".[297]

239 The allegations made by SPT 96 led to a major inquiry. BR 26 described him as "troublesome", which led to him being transferred from the junior to the senior school.[298] Following the publication of an article in the *News of the World* on 22 August 1993 quoting allegations by SPT 134, SPT 96 wrote to the Chief Constable and made allegations of sexual abuse, naming BR 26 and three other brothers.[299] SPT 96 quoted other boys as witnesses and the police made thorough enquiries, attempting to contact all 318 boys who had been at St Patrick's during that period. Of the 155 with whom they made contact, only six made allegations, three of which concerned DL 137. When questioned by the police there was virtually no corroboration of SPT 96's allegations.[300] No action was taken.[301] HIA 51 persisted with his allegations, and was finally given detailed reasons by the Director of Public Prosecutions as to why they had not prosecuted BR 26.[302]

240 On deciding to investigate, the police informed the Northern Ireland Office of their enquiries. The NIO informed the Inspectorate, and they decided to tell the Bishop, with a view to the suspension of BR 26, who was at this time the Principal of the school. The NIO and the Inspectorate met Bishop Farquhar and Father McCann, the Chair and Secretary of the Board of Management, who then considered the situation.[303] They said that they consulted BR 26, who had denied the truth of the allegations. They believed BR 26, who was held in high regard, as both men had been

295 SPT 2195.
296 SPT 26005-26006.
297 SPT 2194.
298 SPT 2195.
299 SPT 20603.
300 SPT 20868-20869, 20608-20615.
301 SPT 20577.
302 Day 146, pp.33 to 37.
303 SPT 12924-12941.

Chaplains at St Patrick's,[304] and the Bishop decided not to suspend him, as this would have had a major (and in his view unwarranted) impact on BR 26's career and the running of the school. In the light of the Bishop's decision, the NIO decided to adopt a watching brief.[305] BR 26 said in oral evidence that the allegations had not been put to him by the Bishop, and he learnt of the concerns when contacted by the police.[306]

241 The allegations related to 1960, and were therefore 35 years old, and the police concluded that there were insufficient grounds for them to take action. BR 26 co-operated voluntarily with their inquiries as he wished to ensure that his name was cleared. The Diocese concluded that their action had been correct in deciding not to suspend BR 26. The matter was not mentioned in the minutes of the following Board of Management meeting. It should be noted that neither the NIO nor the Inspectorate had the power to suspend BR 26, though they could have exerted pressure on the Board of Management, at the risk of upsetting the Catholic Church.

242 **It is our view that, taking account of current practice in the mid-1990s, Bishop Farquhar was at fault in failing to suspend BR 26 during the police enquiries and in undertaking their own limited investigation, and that these failures were systemic, potentially putting the boys then and subsequently at St Patrick's at risk.**

243 The police felt that the evidence against BR 26 was insufficient to take action. In all they interviewed him seven times, and on every occasion concluded that the evidence would not support action. The conclusions reached by the police have to be interpreted in the context of developments at that time. There was still mistrust of the police in some sections of the population, which could have dissuaded some former residents from disclosing abuse. The police were, of course, seeking reliable evidence for prosecutions where the verdict would be beyond reasonable doubt. Furthermore, less credence was placed then in the evidence of the victims of alleged abuse, particularly in view of their histories as offenders.

244 We heard evidence from witnesses who spoke highly of BR 26 and who found the allegations of abuse unbelievable. SPT 125, for example, said that he found the allegations of abuse against BR 26 incredible. BR 26 could have groomed him, he said in oral evidence, as they spent time together walking round the campus and talking, but he never sensed

304 Day 157, p.58.
305 Day 149, p.60.
306 Day 157, p.55 to 56.

anything but concern on BR 26's part, and the description of BR 26 as an abuser was "not the man I knew".[307]

245 There can be no doubt that BR 26 devoted his life to St Patrick's, and made a major professional contribution to it and the boys who were in its care over more than four decades. Those who worked with him and gave evidence to the Inquiry hold him in the highest regard, and do not believe that he could have behaved in the manner alleged.

246 It has to be acknowledged, however, that the history of residential child care contains many examples of eminent people who have had excellent reputations as qualified professionals, who have helped many children in their care, and who have often been intelligent, cultured, charming and even charismatic, but who have nonetheless abused some of the children for whom they were responsible.

247 A significant number of former residents of St Patrick's have made allegations of sexual and physical abuse by BR 26 over many years, although when we examined their accounts in detail we considered that many of the allegations were not persuasive for various reasons. Some of the allegations suggest that the abuser may have been misidentified, and some allegations do not meet the necessary standard of proof on the balance of probability. Having considered all of the evidence we are not persuaded to the necessary standard of proof that BR 26 sexually abused boys in his care, although his practice of delivering comics to boys at night left him open to allegations of grooming. However, we are satisfied to the necessary standard that BR 26 did beat boys on occasion, and used physical force to maintain control, in accordance with St Patrick's traditional training school way of working.

DL 137

248 DL 137 was born on 10 May 1955; between the ages of 13 and 15 he lived at Rubane and he alleged that while he was there he was sexually abused. He was taken on as an Assistant Chef at St Patrick's on 22 February 1975 when he was nearly twenty years old, presumably as an example of the brothers fulfilling their responsibility to find jobs for boys leaving their homes.

249 It was in 1978, when he had been working at St Patrick's for more than three years, that two boys reported that DL 137 had offered them money in return for sexual favours. On 9 July 1978 he was questioned by the

307 Day 140, p.103.

Brother Director, then BR 95, who gave him a "severe warning" and forbade him to mix with the boys.[308] There is no reference to this episode in the Board of Management minutes, which suggests that BR 95 decided not to report the matter. No further problem was identified prior to the events that led to DL 137's departure from St Patrick's.

250 Two years later further complaints were made that DL 137 had sexually abused boys. SPT 53 found SPT 140 crying, as DL 137 had offered him cigarettes to put his hand down his underpants. This was the first time that SPT 53 had encountered this problem and he informed BR 95, who called DL 137 in. On 12 March 1980 BR 95 suspended DL 137 and considered the options open to him. The outcome was that DL 137 signed a letter of resignation and left St Patrick's.[309] SPT 53 witnessed DL 137's resignation, but he was not sure whether DL 137 had committed an offence.[310] BR 26 also witnessed the resignation, and recalled in evidence that this was the first he had heard of DL 137's misconduct, other than rumours.[311] SPT 40 said that he had heard no more than gossip and rumours within the school community, but he made sure that DL 137 had no contact with the boys in his chalet.[312]

251 BR 95 decided that no further action was required, and therefore did not report the allegations to the police or to the Brother Provincial.[313] Again, there is no reference to the matter in the minutes of the following Board of Management meeting, other than that DL 137 had resigned.[314] It is possible that the Brother Director informed the Board confidentially and that they decided that discretion was necessary for the good name of the school, but there is no mention in subsequent documentation that this was the case; it seems more likely that BR 95 felt that 'least said, soonest mended' and kept the matter to himself.

252 Six months later BR 95 gave DL 137 a positive job reference, making no mention of the reason for his resignation from St Patrick's and describing him as diligent, conscientious and punctual.[315] DL 137 went on to commit further sexual abuse, and eight years after he left St Patrick's, on 27 September 1988, he was convicted of sex offences and sentenced to four

308 SPT 21365, 21382.
309 SPT 21369.
310 Day 145, pp.44 to 46.
311 Day 157, p.46.
312 Day 145, p.12.
313 Day 149, p.20.
314 SPT 80999.
315 SPT 21368.

years in prison. Men who had been resident as boys at St Patrick's during DL 137's employment then came forward to make allegations of abuse. He was prosecuted for offences committed between 1977 and 1980, and he pleaded guilty to gross indecency but not buggery. He was convicted on 4 December 1995 fifteen years after he had left St Patrick's.

253 DL 137 died on 24 December 2004. There were further complaints about his abuse of boys after his death, and three civil cases for damages.[316] Consideration was given to the prosecution of BR 95 for concealing DL 137's offences, but it was concluded that the case could not be proved and so the Director of Public Prosecutions directed that he should not be prosecuted.[317]

254 Five of the witnesses to the Inquiry alleged sexual assault by DL 137, including two who gave evidence at his criminal trial: HIA 218, HIA 219, HIA 347, HIA 320 and HIA 227. The following examples indicate DL 137's ways of grooming boys and encouraging them to join him in sexual activity, in some cases despite the Brother Director's warning that he was not to mix with the boys.

255 HIA 320 was at the school in the mid 1970s, and he encountered DL 137. He stated that DL 137 was at that time one of the two chefs, but he also looked after the boys in the evenings and he took them to the swimming pool. HIA 320 recounts that DL 137:

> "... kept putting his hand down my swimming pants and I really didn't understand what was going on because I was so young".

DL 137 also offered him cigarettes to go into the swimming pool to have sex with him, but HIA 320 refused:

> "He was always at me and he would corner me sometimes and let on to jokingly wrestle but I was uncomfortable with this and I was afraid of him."[318]

256 HIA 227 said that DL 137 abused him once, and that when he reported this to the police in 1997 it was one of the cases they used to prosecute him. DL 137 was playing table tennis with HIA 227, when he asked him to go into a room facing the staff canteen; there he started by feeling HIA 227's penis through his trousers and went on to make the boy masturbate

316 SPT 30158-30208, 30905-31015.
317 SPT 26100-SPT26101.
318 SPT 115.

him. DL 137 gave him fifty pence and told him not to tell anyone what had happened; he also invited HIA 227 to go back to the room on a few further occasions, but HIA 227 refused.

257 HIA 347 provided detailed information about five occasions when DL 137 abused him sexually. The first time was soon after his admission to St Patrick's in 1979. On three occasions this was in a store room near the kitchen, where DL 137 encouraged HIA 347 to masturbate him or they mutually masturbated each other. On another occasion HIA 347 happened to meet DL 137 in a swimming pool in Belfast and the abuse took place in a cubicle, where oral sex was attempted. On the final occasion anal penetration was attempted unsuccessfully. HIA 347 asked DL 137 for money, so that he could get a train home, and he felt disgusted with himself when DL 137 gave him £5.[319]

258 In summary, if decisive action had been taken by BR 95 in 1978, when boys first complained about his conduct, the boys whom DL 137 subsequently abused at St Patrick's would have avoided his attentions and those whom he later abused after leaving the school might also have avoided becoming his victims. BR 95 failed to inform either the police or his Board of Management, both in 1978 and in 1980, with the result that many more boys were abused. He compounded his negligent management of DL 137 by giving him a clear reference for further employment. The De La Salle Order has recognised that through the line of action taken by BR 95 as Brother Director they failed to deal with DL 137's offending properly.

259 **We consider the failure of the Brother Director**

(a) to inform both the police and his Committee of the allegations of abuse by DL 137 in 1978 and again in 1980,

(b) to dismiss DL 137, permitting him to resign,

(c) to protect potential victims of sexual abuse in providing DL 137 with a positive job reference which omitted the reason for his departure from St Patrick's

to be systemic failures.

Peer Sexual Abuse

260 There are only three references to peer sexual abuse prior to the mid-1980s. HIA 100 said he was aware of peer sexual abuse in the mid-1960s, and that two boys abused him. He said that BR 47 turned a blind

319 SPT 159-161.

eye to boys' sexual behaviour and that no one was ever punished for peer sexual abuse.[320]

261 HIA 314 alleged that sexual activity took place during the boys' Saturday trips to the cinema as there was only one person in charge of them:

> "Everybody knew what was going on but nobody said anything. Masturbation was normal among the inmates and certain groups of older inmates would abuse the younger ones who were brought into their cliques."[321]
>
> "Sexual intercourse was not discouraged between the boys".[322]

262 HIA 162, who was in St Patrick's from 1973-1974, was "small and looked very feminine at that time" and he had "terrible experiences" when he shared a dormitory with the older boys on holiday in Cushendall. For the first week they made him give them oral sex and masturbate them; he then ran away, and believes that the staff must have known what was happening.[323]

263 BR 26 said that he came across sexual activity among boys occasionally, and dealt with it by talking to the boys and explaining that such behaviour was unacceptable. The boys involved were sometimes moved to other dormitories. There was informal discussion about the problem at housemasters' meetings, but there seems to have been no formal policy adopted or concern expressed to or by the Board of Management.[324] In treating sexual activity as a behaviour which needed to be dealt with in the normal run of school life, it is possible that it was thought unnecessary to record such incidents.

264 Possibly following the publication of the Hughes Report in 1985, the practice changed, in that sexual activities among boys were reported to the police, as will be seen in the instances reported below. The focus of the Hughes Report had been on allegations of the homosexual abuse of boys by staff, and all homosexual relations had been against the law in Northern Ireland until 1982. No action was taken by the police concerning peer abuse among boys at St Patrick's, however, but BR 26 said that the fact that cases were referred perhaps led to a diminution in the number of occasions on which boys were involved.[325]

320 Day 138, p.152.
321 SPT 004.
322 SPT 005.
323 SPT 109.
324 Day 157, p.50.
325 Day 157, p.52.

265 On 15 February 1986 BR 42 found two boys in their bedroom engaged in consensual buggery. He moved one of the boys into a different bedroom and reported the matter to the police. Their enquiries uncovered homosexual contacts with men in the community involving three other boys as well. The police took no action against any of the boys as their sexual activity was seen as experimentation, but one of the adults was given a suspended prison sentence.[326]

266 On 19 October 1987 a boy, SPT 104, told his housemaster SPT 52 that he and another boy SPT 103 had been engaging for four months in consensual mutual buggery, but that he wanted to stop because of the risk of AIDS. SPT 52 informed BR 26, who contacted the police. The boys were questioned by the police. Further sexual activity with two other boys in the community was disclosed, but the other boys were not identified.[327]

267 On 4 February 1988 a 12 year old boy SPT 106 complained that a 15 year old boy, SPT 105, had sexually assaulted him while they were absconding from St Patrick's. Police interviews revealed consensual mutual buggery over a longer period.[328] No action was taken despite their difference in age.

268 On 18 May 1994 a 14 year old boy, HIA 384, made allegations of sexual assault against a 15 year old, SPT 54, who was questioned by the police, but denied all the allegations. The 15 year old was, however, charged with buggery, gross indecency and indecent assault and placed in Lisnevin, later returning to the secure unit at St Patrick's. Following further investigations the police concluded that "both parties were, to a certain extent, willing participants", despite an element of bullying. The 14 year old withdrew his allegations. The situation was complicated by allegations and counter-allegations involving two other boys other boys, SPT 61 and SPT 63. The police concluded that the evidence was too unreliable for them to take action.[329]

269 In a large residential establishment for boys sexual behaviour of the type reported above can be expected from time to time. Although some coercive bullying was involved, the activities appear to have been largely consensual. When the staff of St Patrick's received allegations they took appropriate action, whether dealing with the matter themselves prior to 1985 or reporting allegations to the police thereafter. There is no indication that the

326 SPT 20157, 20164, 20169.
327 SPT 20392, 20400, 20401, 20409, 20410, 20418.
328 SPT 20425, 20426.
329 SPT 21144, 21148, 21149, 21162, 21176, 21189, 21194.

allegations were more than a series of isolated incidents or that there was a culture of peer sexual abuse which staff were neglecting. There is therefore insufficient evidence to suggest systemic abuse.

Physical Abuse by Staff

270 In the early years, the regime at St Patrick's was clearly fairly harsh. A small number of staff had the responsibility for maintaining control of a large number of boys, some of whom had long histories of offending and some of whom were seriously disturbed. Corporal punishment was used to keep order, sometimes according to the Training School Rules, with beatings witnessed and recorded, and sometimes informally, with cuffing and slapping with straps. When boys had misbehaved they accepted that such punishments were fair, but they resented what they saw as unwarranted punishments or excessive levels of violence. In 1948 there was an ecclesiastical inquiry into an allegation of physical assault, and as a result BR 70 was suspended, but following an investigation by the Ministry he was re-instated, as the boy making the allegations, SPT 30, was deemed an unreliable nuisance, and a hundred boys had petitioned for the brother to be allowed to stay on.[330]

271 HIA 229 wrote:

> "The regime at St Patrick's was very violent because a number of the brothers were very violent. I was terrified of them. I received a beating with a leather strap and was punched and kicked. It went far beyond any chastisement for misbehaving. [BR 4] slapped me frequently and he used a strap most of the time. I remember one occasion that I was standing in the corridor and he was carrying a bunch of keys in his hand. For no reason at all, he hit me on the side of the head with the keys. I could not hear properly for about a week but I did not receive any medical attention. I was too afraid to ask for help."[331]

272 HIA 282 wrote that when he was admitted in 1964 he was well treated at first:

> "However after a few days I started to get smacked on the back of the head or kicks on the backside when the Brothers were walking past me. These were for no reason whatsoever. The Brothers simply hit you and walked on without saying a word. This happened to me and to other boys frequently. I literally became afraid of them …".[332]

330 SPT 10553, 10555.
331 SPT 010.
332 SPT 041-042.

273 HIA 282's stay at St Patrick's was not long, and shortly before he left he:

> "must have received ten or fifteen thumps with the strap on my head and back"

for dropping crumbs from a sausage roll he was eating. There were marks all over his back and "a couple of lumps" on his head. When he got home his father happened to see the marks on his back, and went with a friend to confront the brothers, who threatened to call the police.[333]

274 HIA 100 named three brothers, BR 83, BR 94 and BR 47, as being violent or frightening. He wrote:

> "You would get the odd punch in the ribs, you were forever getting slapped and hit across the back of the head and stuff like that. They would hit you if you were cheeky or did not do what you were told but to be honest they did not need an excuse to hit you. I was just riddled with fear of them all the time."[334]

275 HIA 58 said that he was thrown into the swimming pool when he was unable to swim for attempting to abscond. He wrote that BR 26, a "tall skinny brother" and two others threw him into the "six foot end", and that it was "torture" to him; he never learned to swim but is still very scared of water as a result:

> "The punishment was so bad that I only tried to escape twice".[335]

276 HIA 272 described the way that BR 5 strapped him in the gym on a Sunday morning in front of the rest of the boys and other staff. He was bent over a chair in his boxer shorts and was given "six whips of the strap", which was made of leather, about eighteen inches long, with a split in it. These punishments were for theft and breaking a window.[336]

277 HIA 344 was admitted to St Patrick's in 1973; his main complaint concerned two lay housemasters, SPT 1 and SPT 2, alleging that they frequently slapped him on the back of the head, hit him with boots and flicked wet towels at him like a whip, causing big welts on his back and the backs of his legs. When he broke a saw blade, he was also punched in the eye by a woodwork teacher, SPT 89, resulting in a black eye. He puts his absconding mainly down to a wish to escape the physical abuse, and

333 SPT 044.
334 SPT 050.
335 SPT 057, 058.
336 SPT 080-081.

his description of life at St Patrick's otherwise indicates satisfaction with conditions. However, his absconding ended with his removal to Crumlin Road Prison and then Armagh Borstal.[337]

278 HIA 94 was also admitted in 1973, and like HIA 344, he alleges that the same two housemasters, SPT 1 and SPT 2, beat him when he was placed in a cell as punishment. He also states that on a few occasions the brothers made the boys get in a shower naked and then beat them with a strap with lead in it.[338] HIA 94 had been moved from Rubane when he was beyond control there, and after seven months at St Patrick's he was moved on to Lisnevin for the same reason.[339]

279 HIA 320 was in St Patrick's in the mid to late 1970s and he described a violent atmosphere, with "a few members of staff who were a bit vicious", including both housemasters, SPT 2 and SPT 78, and brothers, naming BR 4. Boys were punched or beaten with straps. SPT 2 said that he had had to man-handle HIA 320 into a time-out room, but never assaulted him. He also cast doubt on HIA 320's evidence.

280 HIA 227 was at St Patrick's in the same period as HIA 320 and he also noted the use of the leather strap by housemasters and the extensive bullying by older boys. As he was one of the youngest boys in the school he found it "hell at times".[340] HIA 54 was also there in the same period, and he recalled the brothers beating boys with leather straps and being hit over the head with a bunch of keys by BR 50.[341]

281 HIA 50 was only in St Patrick's briefly at the end of 1986. He says he was beaten daily by two boys, but it was the caretaker whom he feared, who caned him across his "back, head, neck and across the back of the legs" when the police returned him from absconding.[342] HIA 275, who was admitted in 1987, made a similar statement about a watchman SPT 64, who:

> "physically assaulted me almost every time I returned to St Patrick's after absconding. He threw me into a cold shower and beat me with a big blackthorn stick he used to have. He hit me up to fifteen times with the stick and I was often bruised."

337 SPT 091-092.
338 SPT 099.
339 SPT 100.
340 SPT 129.
341 SPT 152.
342 SPT 187.

Another lay member of staff was cruel and hit him with wet towels or a bunch of keys. He had no complaints about the brothers.[343]

282 BR 94 candidly stated that he strapped boys and gave some a clip round the ear.[344] Otherwise, the brothers and lay staff who gave evidence all denied physical abuse. Formal recorded punishments were acknowledged, but the excessive and informal punishments described above were denied. We did not find the denials persuasive.

283 The accounts of the former residents and former staff of physical abuse are clearly at odds, but the volume and detail of the allegations are more persuasive than the denials. The emotional weight attached to the physical attacks will probably have rendered their memory more significant to the victims than to the abusers. It should be noted that most of the allegations of physical abuse relate to the 1960s and early 1970s. The abuse alleged in the 1980s appears to have related largely to one member of night staff. This would suggest that the practice of casual physical abuse as a means of control generally died out in the last two decades of St Patrick's existence. **The prevalence of unauthorised physical punishment in the 1960s and early 1970s was, however, contrary to the Training School Rules, and constituted systemic abuse.**

Peer Physical Abuse

284 There appears to have been an undercurrent of violence and bullying which came and went from time to time, depending in part on the discharge of older boys who, sometimes in groups, intimidated younger ones. It is a common feature in residential child care that the atmosphere established by the staff is replicated among the children, whether for good or ill, and where the atmosphere is abusive it can have a corrupting effect. The harsh regime imposed by the staff in the 1960s and early 1970s, with the use of physical force to maintain control, may therefore have provided a model for relationships among the boys. Many of the boys will, however, also have experienced violence at home or been belted at school or, during the Troubles, even experienced punishment beatings, or the threat of them, at the hands of paramilitaries. Physical punishments by staff will only have confirmed such boys' experience that 'might is right' in obtaining what they wanted.

343 SPT 193.
344 Day 147, pp.31 and 32.

285 HIA 162 described an occasion when two older boys who used to beat him took him to Black Mountain and "tortured" him, saying that they were from the IRA (a claim he did not believe) and that he was an informer. He was bleeding and bruised when he got back to St Patrick's but he received no treatment. This appears to have been a one-off event.[345]

286 HIA 162 said that birthdays were celebrated by boys gathering round, singing "Happy Birthday" and then giving the birthday boy a kicking.[346]

287 HIA 320 commendably admitted to having become a bully in order to survive, a fact of which he is now ashamed:

> "There was frequent bullying going on and I ended up being a bully myself. There was a tier system between the boys and I was able to handle myself but I hate myself for that today".[347]

288 In view of the limited range of examples provided by witnesses, peer physical abuse does not seem to have been a persistent problem.

Emotional Abuse

289 HIA 96 was the only witness to allege that he had been emotionally abused. He felt that he had been "kidnapped" by the state and should not have been at St Patrick's at all.[348] He therefore saw any denial of contact with his family as emotionally abusive, and alleged that staff manipulated the points system so that he could not go home.[349] He also alleged that he was placed in Slemish House for punishment without justification, after an incident had escalated when he fought back after an unjust accusation.[350] While we have no reason to doubt the allegation, no other witnesses alleged emotional abuse.

290 As it was a large institution, much of the care offered by St Patrick's must have been fairly basic and impersonal; it would only have been in its last two decades that staffing was sufficient to pay adequate personal attention to individual boys. However, unlike some of the other large homes we have considered, a substantial number of the boys came to St Patrick's from their family homes and they had experienced parental care in their early years. Indeed, continued contact with families was encouraged at

345 SPT 108.
346 Day 140, p.64.
347 SPT 115.
348 SPT 217.
349 SPT 221-222.
350 SPT 221.

St Patrick's, and many boys were visited regularly and/or went home at weekends. They would not, therefore, generally have experienced the emotional deprivation that children brought up throughout their lives in residential care from nursery onwards would have suffered.

291 It is our conclusion that emotional abuse was not a systemic problem in St Patrick's.

Neglect

292 Some witnesses said that they were always hungry, or that their clothes were second-hand, but such references were few. Others said that they did not receive medical treatment for injuries, such as HIA 26. He slashed his wrists and BR 26 cleaned and bandaged the wounds.[351] In view of the large numbers of boys who were admitted to St Patrick's over its lengthy history, these allegations do not present a picture of neglect sufficient to term it systemic. This conclusion does not invalidate the witnesses' experiences, but reflects the need for more substantial evidence to determine that problems were systemic.

Allegations of Unacceptable Practices

Silence at Meals

293 HIA 100 mentioned that when he was at St Patrick's, from 1964 to 1966, boys were not allowed to speak at meal times.[352] He recalled an incident in which eight boys had been lined up for talking in dinner.[353] Requiring silence in mealtimes was a carry-over from earlier institutional practice when it was a common means of maintaining order if a large number of children were gathered in one place, since the maintenance of control was a sine qua non of such establishments.

294 However, by the mid-1960s child care practice was changing and, since meals were now thought of as social occasions, maintaining silence was considered poor child care, though it could not be termed systemic abuse. The practice generally changed when smaller units were introduced and meals could be taken in family-sized groups. When the chalets were opened at St Patrick's, for example, the boys ate in their units in groups of about ten.[354]

351 SPT 074.
352 Day 138, p.128.
353 Day 138, p.128.
354 Day 140, p, 85.

Excessive Chores

295 Unlike some other homes, there were few allegations about boys having to do excessive chores. HIA 58 said that he had to polish three dormitories on his own, "when the Belfast boys were out" with cloths under his feet, and that he had to wash pots and pans in the kitchen for six months, suffering dermatitis as a result.[355] Again, while such demands would have been excessive, the small number of complaints does not amount to systemic abuse.

Interception of Post

296 HIA 58 said that in the late 1960s his mother enclosed money in her letters which did not reach him,[356] and in the early 1970s HIA 162 alleged that letters were put on his file and were not given to him.[357] HIA 384 also complained that his mail was intercepted in the 1990s when he was in Slemish House, which was at that time a secure intensive care unit.[358] As a member of staff, SPT 2 said that the post in Slemish House was not intercepted, but that boys opened their letters in the presence of staff.[359]

297 It would have been reasonable practice for money to be removed from letters and banked for the boys, in order to avoid the temptation of theft by other boys or the use of the money for inappropriate purposes. It would have been unacceptable for children and young people to be prevented from reading their letters unless there were exceptional reasons, but during much of the Inquiry's remit post would still have been intercepted and possibly read before it was passed to children in some homes and schools. The practices described by HIA 158 and HIA 62 would therefore probably have been unacceptable. However, there is insufficient evidence that the practice was widespread and we are not persuaded that it amounted to systemic abuse.

Failure to Take Action

298 A number of witnesses said that they informed other people who they thought would be sympathetic that they were being abused, but that they were not believed. In some cases the people approached simply felt it was beyond belief that brothers would abuse children sexually. It was also

355 SPT 058, 059.
356 Day 139, p.16.
357 Day 140, p.29.
358 SPT 50165.
359 Day 143, pp. 83 and 84.

because of this perception that boys did not report abuse, for example to their parents.

299 HIA 314 wrote:

> "I couldn't tell my parents about the abuse as they were very religious and would not accept that a member of the Catholic Church would do such a thing. There were two nuns there and they must have known about the abuse. We tried to mention it to the nuns because we thought we might get a bit of support or help from a woman but they just called us liars and hit us."[360]

300 HIA 229 told the bandmaster, who was strict and demanding but "a good man", about the abuse boys were suffering. The bandmaster told HIA 229 to leave it with him, but HIA 229 heard no more and does not know whether he took action.

301 HIA 272 told his housemaster SPT 2 whom he considered "a genuine and good person" about the abuse he was suffering. SPT 2 wrote out a statement and said he was going to act on it; HIA 272 heard no more, but surmises that SPT 2 was in a difficult predicament as he would have lost his job if he had complained. HIA 272 also mentioned a news story about abuse to his mother, but she did not want to believe that brothers would abuse people.[361] SPT 2 denied that he recorded HIA 272's statement and that he failed to take action in consequence. He pointed out that there was no corroboration of HIA 272's account, and that his job would not have been at risk if he was simply acting as a messenger on HIA 272's behalf. He said he would have acted on a report of sexual abuse.

302 HIA 162 made a complaint to one of the welfare staff, SPT 48, and he alleged that within an hour he was beaten and placed in a punishment cell where he was kept for three or four days. The cell had no windows but light was admitted through glass bricks. There was a hard bed with half a mattress, no food and no call system.[362] The brothers denied that any boy was held in a cell for this length of time.

303 HIA 314 reported that he had told the Bon Secours nuns who worked at St Patrick's about the abuse he had suffered. They called him a liar and hit him. The nuns may have been SR 74 and SR 75.[363]

360 SPT 006.
361 SPT 083-4.
362 SPT 110.
363 SPT 006.

304 In all of these cases, the proper practice was of course that those in receipt of complaints should have taken matters up with appropriate senior managers, or other responsible persons. However, for much of the period covered by the Inquiry's remit, the common way of thinking was that children who made allegations lacked credibility and it was unthinkable that religious and professionals would abuse children. People taking up the complaints also could possibly have jeopardised their jobs or their working relationships with their colleagues, and would have had to face the authority of the Roman Catholic Church or the state. It is understandable therefore at a human level if they failed to put themselves at risk in this way and challenge the system.

305 The Brothers, however, as a matter of good practice, should have created an atmosphere in which both staff and boys felt able to make complaints and report abuse. **We consider it a systemic failure that a culture existed that meant that potential whistle-blowers felt unable to speak up.**

306 Following the introduction of new complaints procedures with the Children Order 1995, there should now be no excuse for individuals who fail to report allegations of abuse.

307 As noted above, the police followed up the allegations made by SPT 96 against BR 26 and others very thoroughly.

Conclusion

308 St Patrick's played a key role in the training school system in Northern Ireland, providing education, trade training and care for boys from the Roman Catholic community. For the most part it appears to have fulfilled this role effectively, admitting 4,537 boys in the course of its 126 years history. The physical standards of care provided were adequate; the regime could be described as harsh, but for much of the time it was no more punitive than the day school system in the wider community, and HIA 96's description of the school as a "war zone", a continuous battle between staff and boys in which the state and Church combined to hold boys against their will, is not supported by the evidence of other witnesses.[364]

309 The main defect in residential care practice at St Patrick's was the persistent high level of absconding. The proximity of the school to the city of Belfast certainly exacerbated this problem but, although some

364 Day 142, p.123.

measures were taken such as the opening of the secure unit in Slemish House, this issue was never adequately addressed or solved.

310 The Troubles presented acute problems for the school. Managing a large school for young offenders and disturbed adolescents is an exceptionally difficult task at the best of times, and it is to the credit of the staff and managers that St Patrick's kept going throughout this difficult period. It was, however, during the Troubles that one of St Patrick's two tragedies occurred with the death of Bernard Teggart, abducted and murdered by the IRA. The conduct of some of the staff during this episode was also questionable.

311 The second tragedy was the death of SPT 81, accidentally run over by other boys from St Patrick's, 'joy-riding' while absconding. The event highlighted the need for improvements in staffing and staff deployment, as well as the serious dangers associated with absconding.

312 There was both physical and sexual abuse at St Patrick's. There were three members of staff - two brothers and a chef - who between them were the source of about a third of the allegations of sexual abuse. All three were investigated by the police, who for different reasons took no action in relation to the two brothers, but the chef served a prison sentence for his offences. The remaining allegations were made against 24 brothers, 1 priest and 10 lay staff, or 38 adults in total, mostly in ones and twos in different years, suggesting no particular pattern of systemic abuse, though in the early 1960s there were allegations that there was a culture of low level sexual abuse in public among the brothers.

313 The allegations of physical abuse for the most part seem to have reflected the harsh regime, but there were a few occasions when formal punishment was excessive and there were periods such as the early 1970s when staff appear to have indulged in casual unjustified attacks on boys, perhaps as a way of asserting their control but creating an atmosphere of violence in the process.

314 Unsurprisingly in a large establishment for boys there was bullying, fighting, peer physical abuse and peer sexual abuse, perhaps partly influenced by the model offered by some of the staff and partly arising from the earlier experiences of boys who had suffered abuse at home.

315 At the start of the period covered by the witnesses' evidence the school moved from Milltown to a new large building in Glen Road, and was over time remodelled by providing smaller units and a more homely model of care. Staffing and staff training were also considerably improved. In consequence over its last four decades the school developed from a highly institutional

regime to a residential social work model, which by the time of the school's closure was well up to date.

316 Without in any way diminishing the significance of the two tragic deaths or the suffering of the 24 applicants who shared their experiences of abuse at the hearings of the Inquiry, these failings have to be seen in the context of the 4537 boys who went through the doors of St Patrick's, some of whom clearly enjoyed and benefited from their stay.

317 On behalf of the Diocese of Down and Connor the Very Reverend Timothy Bartlett expressed their sincere and profound apologies to any person who had been abused while at St Patrick's, especially in view of the high ideals espoused by the members of the Order when acting in loco parentis.[365]

Summary of Findings

318 The following are the issues which we consider constituted systemic abuse at St Patrick's:

(a) We consider that the failure of St Patrick's to conform to the Training School Rules in respect of secure accommodation and of the Inspectorate to note the breaches and take action, constituted systemic abuse. (Para. 75)

(b) We consider the use of informal corporal punishment was systemic abuse. (Para. 84)

(c) We consider that permitting older boys to punish others when supervising them in the dormitory was a breach of the Training School Rules and was systemic abuse. (Para. 88)

(d) The humiliation of stripping a boy naked to stand in full view on a number of occasions constituted systemic abuse. (Para. 91)

(e) The failure to report the abductions of Bernard and Gerard Teggart to the Police was clearly a systemic shortcoming on the part of the Brother Director. The failure of the Board of Management to meet immediately after the boy's death, to investigate and to provide support to the staff and boys was negligent and constituted systemic abuse. (Para. 119)

(f) There is nothing to suggest that the NIO took any steps following the death of Bernard Teggart to investigate whether any policies or procedures needed to be changed to protect

365 SPT 855.

boys from suffering a similar fate, and their failure to do so represents a systemic failing on their part. (Para. 120)

(g) Statistical returns concerning absconding were provided by St Patrick's to the NIO and these records would have been open to Inspectors when they visited. Prior to the concern raised by the death of SPT 81 neither the NIO nor the SSI had raised absconding as a major issue with St Patrick's and we consider this a systemic failure on their part. (Para. 136)

(h) The failure to circulate the findings of the report on absconding from Rathgael more widely and assist St Patrick's in finding ways of dealing with persistent absconding was a systemic failure on the part of the NIO. (Para. 137)

(i) Furthermore, the APRU, which had been set up as a combined unit to support all the training schools and which had undertaken the research on absconding, also failed to share their findings with St Patrick's, when they must have known that it had a similar problem. (Para. 138)

(j) The failure of St Patrick's to take adequate measures to counter absconding constituted systemic abuse, in that it left boys vulnerable in terms of the risks they faced when absconding, in the patterns of criminality which were fostered while absconding, and in the effect of their absconding pattern on their later lives. (Para. 141)

(k) We consider that the frequency with which the secure rooms were used and their use for young children, contrary to the Training School Rules, amounted to systemic abuse on the part of St Patrick's and by the SSI in failing to address this breach of the Rules. (Para. 168)

(m) The failure to appoint sufficient staff amounts to negligent management, and we consider it to be a systemic failure. (Para. 178)

(n) St Patrick's was not inspected between 1971 and 1988, and we consider the lack of formal inspections a systemic failing. (Para. 186)

(o) We therefore consider the sexual abuse perpetrated by the Brothers, particularly as reported in the television room, to have been systemic. (Para. 223)

(p) The Order has stated that they do not see the allegations as well founded, but it is our view that BR 1 sexually abused boys while he was at St Patrick's and that this constituted systemic abuse; if he had been apprehended and had not been promoted to be Brother Director of Rubane House, the boys there would not have been abused by him. (Para. 229)

(q) It is our view that, taking account of current practice in the mid-1990s, Bishop Farquhar was at fault in failing to suspend BR 26 during the police enquiries and in undertaking their own limited investigation, and that these failures were systemic, potentially putting the boys then and subsequently at St Patrick's at risk. (Para. 242)

(r) We consider the failure of the Brother Director:

- **(i) to inform both the police and his Committee of the allegations of abuse by DL 137 in 1978 and again in 1980,**
- **(ii) to dismiss DL 137, permitting him to resign,**
- **(iii) to protect potential victims of sexual abuse in providing DL 137 with a positive job reference which omitted the reason for his departure from St Patrick's to be systemic failures. (Para. 259)**

(s) The prevalence of unauthorised physical punishment in the 1960s and early 1970s was contrary to the Training School Rules, and constituted systemic abuse. (Para. 283)

(t) We consider it a systemic failure that potential whistle-blowers felt unable to speak up. (Para. 305)

Chapter 13:

Module 7 – Youth Justice Institutions: Introduction

Introduction

1 This Introduction deals with a number of different types of institution which admitted young offenders. Over the period covered by our Terms of Reference the legislation governing these institutions, the names by which different types of institution were known and the institutions themselves all changed as the systems evolved.

2 In Module 4 we considered Nazareth Lodge, which was an industrial school until 1950. In Module 7 we heard witnesses from St Patrick's, which was an industrial school and reformatory until 1950, when it became a training school. In the same Module we also considered Rathgael, a training school which admitted both boys and girls, a few of the witnesses having also been in Malone or Whiteabbey, Rathgael's predecessors. We also heard from applicants who had been in Lisnevin, a secure training school, and Hydebank, a young offenders' centre. In Module 10, witnesses who had been in Millisle, a borstal, gave evidence. In Module 11 we heard from applicants who had been in St Joseph's, which was the only training school specifically for girls which we considered. The purpose of this Introduction is to explain the differences between the types of institution and the way in which the system evolved.

History

3 In the first half of the nineteenth century there were no specialist institutions for children and young people. Young offenders were sent to prisons which were for adults, and children in need were placed in workhouses. Two Acts in the second half of the nineteenth century provided the basis for institutional care in Ireland for children and young people for nearly a hundred years, establishing the reformatories and industrial schools which were later transformed into training schools.

4 It was common practice to base legislation for Ireland on laws which had been passed for England and Wales. Following the Reformatory Schools (Youthful Offenders) Act passed in 1854 "for the training and reformation of older boys who had committed offences against the law" in relation to England and Wales, the Reformatory Schools (Ireland) Act was passed in 1858, with a view to keeping young offenders out of adult prisons in Ireland, though it was 1893 before it ceased to be mandatory for children to spend an initial period in prison before being moved to a reformatory.

5 Malone Reformatory, which was Rathgael's predecessor, was opened in 1860, and in 1872 a training ship, HMS Gibraltar, was moored in Belfast harbour.

6 A decade after the Reformatory Schools Act, following the Industrial Schools Act 1857 in England and Wales, the Industrial Schools (Ireland) Act 1868 provided for setting up Industrial Schools for:

> "neglected, orphaned or abandoned children", "for the rescue and care of younger boys…who were in danger of becoming delinquent".

In part, this Act was designed to help children avoid placement in a workhouse. To be registered, each school was required to draw up rules, to be approved by the Secretary of State, concerning the governance and conduct of the school.

7 St Patrick's was opened as an industrial school for Roman Catholic boys in 1869, and after periods at two other sites in Belfast, it settled in Milltown in 1873, where it remained until 1957. St Joseph's was established for girls in 1881 by the Sisters of St Louis under this Act. On the same site the Sisters also ran an orphanage and a boarding school, which closed in 1942.

8 The Sisters of Nazareth opened Nazareth Lodge in 1900 as a children's home, but in 1902, despite misgivings, it was registered as an industrial school. The number of boys sent to them under court orders appears to have been low, and there were tensions at times because of their need to care for a wide spectrum of presenting problems. Nonetheless Nazareth Lodge retained the role of industrial school until 1951.

9 In 1902 a new type of institution was trialled in England at the village of Borstal, intended as "a half way house between prison and the reformatory" for young offenders. A pilot borstal was opened at Clonmel, Co Tipperary in 1906, but none was opened in what is now Northern Ireland.

10 The Children Act 1908 applied to the whole of Great Britain and Ireland and, known as the Children's Charter, it provided the basis for children's services in Ireland for several decades, establishing juvenile courts, for example. Under this Act reformatories and industrial schools were funded by a combination of central government, local government and parental contributions.

11 With the partition of Ireland in 1921, separate systems of industrial schools, reformatories and borstals had to be established in both Northern Ireland and what is now the Republic of Ireland. At the time of partition a third of the trainees in Clonmel borstal were from Belfast. Boys requiring borstal training in Northern Ireland were sent at first to Feltham in Middlesex, and later to Greenock in Scotland. A Departmental Committee on Reformatory and Industrial Schools in Northern Ireland was set up, which became known as the Moles Committee, and it concluded that a borstal was required in Northern Ireland for males, but that the demand for places for females was too low to warrant setting up a borstal for them. Following the Malone Training School Act (Northern Ireland) in 1926 a semi-secure borstal was sited at Malone, with a single governor responsible for both the training school and the borstal.

12 The Departmental Committee also considered reformatories and industrial schools. A system was established in Northern Ireland which consisted of five industrial schools, four institutions which were both industrial schools and reformatories, and one reformatory. Young people were also admitted to HMP Armagh and HMP Belfast. Some of these institutions were already in existence, and some were newly established. The Departmental Committee on Reformatory and Industrial Schools appears to have rationalised the system, as six of the institutions were either closed soon afterwards or had their roles modified.[1] (see Appendix 2)

13 It was found, for example, that there was no reformatory in Northern Ireland for Catholic boys, and so from 1922 St Patrick's, which had been set up as an industrial school in 1869, was given an additional role as a reformatory, and it was thereafter registered and inspected as both an industrial school and a reformatory, serving both young offenders and boys requiring care and education away from their families. It will be seen that from 1922 onwards the dual requirement to meet the needs of these two groups caused difficulties which were resolved in different ways, but continued to re-emerge, not only in St Patrick's up to the closure of the school in 1996, but also in other institutions serving both groups. St Patrick's was based at Milltown but in 1957 it moved to new premises about a mile away on the edge of Belfast.

14 Malone Reformatory was managed by a voluntary board, but in 1926 it was brought under the Ministry of Home Affairs by the Malone Training

1 SPT 1601-1602.

School Act (Northern Ireland), and in 1927 a borstal wing was added. Prior to this Act, the training school system had been essentially provided by voluntary bodies and the state had no direct control.

15 In England and Wales there were Acts in 1932 and 1933 which served to develop and regulate children's services. Reformatories and industrial schools were renamed approved schools, and the Approved School Rules were introduced. These were standard rules, applied to all the schools for young offenders. The two Acts were not replicated in Northern Ireland for economic reasons, and so the reformatories and industrial schools continued to make use of their own rules under the Acts of 1858 and 1868 respectively.

16 It was recognised that the system needed to be improved and so a working party known as the Lynn Committee was set up. It drew up recommendations for the modernisation of the system in 1938, but the Second World War intervened, and no action was taken.

17 During the Second World War the demand for places in training schools was such that St Patrick's acquired additional premises at Forkhill, Co Armagh which catered for junior boys, with the overall established number increasing to 225.

18 In 1945 Whiteabbey Reformatory School was certified for girls and a year later it was also certified as an industrial school. It was intended to meet the needs of Protestant girls, as St Joseph's served the Roman Catholic community.

19 Major change was required by the time the Children and Young Persons Act (Northern Ireland) 1950 was passed, and it incorporated further developments taken from England and Wales's Children Act 1948. It was in 1952, following the implementation of this Act, that the Training School Rules were introduced, based largely on the English and Welsh Approved School Rules.

20 Rather than use the term 'approved schools', reformatories and industrial schools were all renamed training schools in Northern Ireland, blurring the distinction between the care and justice elements. This term applied until 1996 when the training school system was disbanded following the implementation of the Children (Northern Ireland) Order 1995. The Ministry of Home Affairs (MoHA) was made responsible for the schools, including their finance and inspection.

21 Under the 1950 Act the Sisters of St Louis were invited to register St Joseph's, Middletown, as a training school; in accepting this role they closed the orphanage, though the remaining children stayed on. Malone, Balmoral and Whiteabbey were also registered as training schools. The Sisters of Nazareth, on the other hand, decided that Nazareth Lodge should be registered as a children's home, rather than as an industrial school, as so few of the children in the home were committed by the courts.

22 Woburn House was usually known as Millisle Borstal; it was opened in 1956 and admitted male offenders aged 16 to 21. This was an open borstal, situated in a mansion, but in 1977 a purpose-built closed borstal was opened, sited within the same grounds. Both the open and closed borstals were closed in 1980.

23 In 1956 the Malone and Whiteabbey Training School Act merged Malone and Balmoral training schools and a single Management Board was set up for Whiteabbey and Malone. The borstal wing of Malone was transferred to Millisle; during the previous three decades Malone had been largely staffed by Prison Service staff.

24 Plans were in hand at this point for a purpose-built establishment at Rathgael to take over from Malone training school, but temporary accommodation had to be used as the new premises were not ready. The new buildings at Rathgael were opened in 1968 and Malone was closed. This move was intended to introduce a new approach to the care and treatment of young offenders. In 1985 Whiteabbey School was closed and the remaining girls were transferred to Rathgael, making it the first mixed training school in Northern Ireland, and the only training school for Protestant boys and girls in the province.

25 It will be seen in the histories of the individual homes that the Troubles, which commenced in 1969 and continued for many years, caused considerable difficulties for training schools, because of the number of young people who were involved in civil disorder and required containment in a residential setting. The Troubles led not only to an increase in the number of remands and Training School Orders, but the children and young people in residential care were also at greater risk, for example when visiting their families in areas affected by rioting and housing problems, and it will be seen that the schools themselves were directly affected by the unrest. It was during the Troubles that direct rule was imposed,

and in 1973 the Northern Ireland Office (NIO) took over responsibility for the funding and inspection of the schools, though the MoHA Inspectorate continued to undertake inspections on behalf of the NIO.

26 It was in 1973 that Lisnevin was opened as a training school, consisting of an assessment unit to assist the courts in determining the suitability of boys for residential training and a secure unit for boys who absconded from the open training schools. It admitted both Protestant and Catholic boys. The opening of Lisnevin came at a time of considerable pressure because of the number of adolescents who got caught up in social disorder in the Troubles. Because of pressure from the local community, Lisnevin was resited at Millisle, which had previously been used as a secure borstal.

27 The Treatment of Offenders Act (Northern Ireland) 1968 was designed to introduce a new approach to the management of young offenders, and in June 1979 Hydebank Wood Young Offenders Centre was opened. As a consequence, the open and closed borstals at Millisle were closed the following year.

28 In 1985 a remand unit was opened at Lisnevin. Previously there had been no specialist unit for young people on remand, and the training schools had been expected to provide the service in addition to their usual remit of caring for the boys committed to them.

29 During the period 1979 to 1985 three influential reports were published which all had an impact on the quality of care offered by the training schools.

(a) In 1979 the Black Report was published, which recommended the splitting of the care and justice aspects of training schools and the development of a range of smaller specialist homes. For a variety of reasons, these recommendations were not implemented for some years; it was not until November 1986 that the Prior Compromise led to the adoption of the main principles of the Report, and we have been told that action on some aspects is still outstanding.

(b) The Sheridan Report followed in 1982, recommending improvements in staff selection, supervision and other aspects of the management of residential childcare services.

(c) In 1985 the Hughes Report was published, recommending the professionalisation of residential childcare through improvements in pay and training. Around this time large numbers of training school staff were seconded for qualifying training and the proportion of

trained care staff was greatly improved. The contents and impact of these three reports are addressed more fully in other chapters of our report.

30 The period from the publication of these reports to the end of the Inquiry's remit is marked by a range of improvements, such that by 1995 the quality of residential care in Northern Ireland, including the training schools, was possibly better than in the other countries of the United Kingdom.

31 Among the early developments, in 1981 the Adolescent Psychological and Research Unit was set up, amalgamating the posts of the four psychologists who had previously been attached to individual training schools, so that they were able to provide a service to all the training schools.[2]

32 From the 1980s onwards, the demand for places in training schools began to fall away, and the occupancy was much reduced by the time that the system was disbanded and was replaced by Juvenile Justice Centres under the Children (Northern Ireland) Order 1995. Some of the training school sites continued to be used, however, with St Patrick's renamed Glenmona from 1996 and Rathgael known as Lakeside from 1998. These changes took place shortly after the end of the Inquiry's Terms of Reference.

33 Since little of the evidence we have received predates the 1950 Act, the witnesses' experience related primarily to the schools during the phase when they were known as training schools. The schools were, however, affected by their histories as reformatories and industrial schools, and they were in need of considerable modernisation when the 1950 Act was passed. It will be seen that the institutions in some respects continued to reflect traditional ways of working for some time, but that standards improved throughout the history of the training school system.

Types of Training School

34 Throughout much of the history of the training schools the provision was organised primarily to provide separately for boys and girls, and separately for Roman Catholics and Protestants. There were therefore four main types of school. St Patrick's served the Roman Catholic boys throughout this period, and Malone or Rathgael provided for the Protestant boys; Whiteabbey served the Protestant girls, and St Joseph's the Catholic girls.

2 LSN 1241.

35 Within Rathgael and St Patrick's there was also a division for a time between senior boys and junior boys. There were also often divisions between units designated for young offenders, known sometimes as the 'justice' units and those known as the 'care' units, for children and young people with other types of problem, whose behaviour at times was a greater cause for concern than that of the offenders.

36 Absconding proved a major problem in St Patrick's and Rathgael. One response was the creation of special units within the schools, offering security and intensive care. Another was the creation in 1973 of a secure training school, Lisnevin, which served both Roman Catholics and Protestants.

37 There were therefore five ways in which children and young people resident in training schools might be categorised – by gender, religious denomination, age, history of offending and the need for secure care. The divisions between the residential units which served all these categories of resident within the schools were at times quite marked and the different groups of children and young people were often not allowed to mix, even though they were living on the same site.

38 The Black Report recommended the development of specialist units, but one of the difficulties facing those responsible for planning the system was that the numbers of children and young people falling into some of these categories often fluctuated and could be small. As time went on, attempts were made to blur some of the distinctions described above. In 1973, for example, Lisnevin was set up as an interdenominational secure home for boys, and in 1986 Rathgael took in the girls from Whiteabbey, creating a mixed training school for the first time. Community-based services were also developed, curtailing the demand for residential care, while going some way towards meeting the need for specialist services. These developments appear to have continued after the end of the Inquiry's remit.

Mental Health Services

39 Lissue Hospital provided both paediatric and psychiatric services for children. For most of the time, the upper age limit for admission was thirteen, and very few older children were admitted. There was no other unit offering adolescent psychiatric help in Northern Ireland, and in consequence young people over the age of thirteen had to be placed in adult psychiatric wards or, if their behaviour suggested that they required some form of containment or control, they were placed on occasions in

training schools, even though the placement may not have met their needs. This placed extra demands on training schools staff. If they too could not cope, the young person might have moved on to Millisle, Hydebank or even an adult prison.

The Prison Service

40 A number of witnesses spent periods of time in prisons before they had attained adulthood. However, they did not make allegations of systemic abuse which suggested that the prisons required investigation.

Conclusion

41 The training school system dealt with several thousand children and young people during the 45 years from its establishment to its closure in 1996. During that time the system was adequately funded. Physical standards of care were improved. Schools were built or modernised. Education, trade training and a variety of activities were provided. The schools oversaw home contact and provided social work support to families. Various aftercare programmes were devised and young people were supervised during their periods of licence. Taking account of the standards of the times, the system was professionally well run, and by the end of the period, the quality of service offered appears to have been excellent.

42 The borstal system in Northern Ireland also played a useful role in diverting young men from the prison system, and there were those who regretted its demise.

43 It will be seen that there were recurrent themes running through the development of services for young offenders. There were constant attempts to develop more humane approaches, to offer young offenders ways of breaking their patterns of offending and develop the skills they required for a constructive way of life. There was the need to adapt the systems to match changing needs, for example following the impact of the Troubles. There was the continual problem that institutions often had to meet the needs of different groups of residents or different functions, which were sometimes in conflict, and which the institutions were not equipped to address. Finally, there was the consequent need made explicit in the Black Report to develop specialist services for relatively small numbers of people, and in a province with a population of under two million this problem is likely to be ongoing.

Appendix 1: Chronology

1858	The Reformatory Schools (Ireland) Act was passed.
1860	Malone Reformatory opened.
1868	The Industrial Schools (Ireland) Act was passed.
1869	St Patrick's Industrial School was registered in Donegall Street, Belfast, and in 1873 it moved to Milltown.
1872	HMS Gibraltar was opened as a training ship, moored in Belfast Harbour.
1881	The Sisters of St Louis opened St Joseph's reformatory for Roman Catholic girls.
1893	It was no longer mandatory for children sentenced to a reformatory to spend an initial period in prison.
1902	After opening as a children's home in 1900, Nazareth Lodge was certified as an industrial school.
1906	A pilot borstal was opened in Clonmel, Co Tipperary.
1908	The Children Act known as the Children's Charter was passed, relating to the whole of Great Britain and Ireland. Under this Act reformatories and industrial schools were funded by a combination of central government, local government and parental contributions.
1921	The partition of Northern Ireland and the Republic.
1922	The establishment of a Government in Northern Ireland and the start of the Inquiry's remit.
1923	A Departmental Committee on Reformatory and Industrial Schools in Northern Ireland, known as the Moles Committee, was set up.
	St Patrick's Industrial School was also registered as a reformatory as there was no provision for Catholic boys in Northern Ireland.
1924	St Michael's Industrial School, Lurgan, was closed to boys.
1926	Malone Training School Act (Northern Ireland) was passed.
1927	Part of the reformatory at Malone was converted into a semi-secure borstal for boys.
	Hampton House Industrial School was closed.

1929	St Michael's Industrial School, Lurgan, was closed.
1933	The Sacred Heart Industrial and Reformatory School at Whiteabbey was closed.
1938	The Lynn Committee on the Protection and Welfare of the Young and the Treatment of Young Offenders reported.
1943	Shamrock Lodge ceased to be a reformatory, but presumably continued as an industrial school.
1945	Whiteabbey Reformatory School was certified.
1946	Whiteabbey was also certified as an industrial school.
1949	St Catherine's Industrial School in Strabane was closed.
1950	The Children and Young Persons Act (Northern Ireland) was passed, amalgamating the industrial schools and reformatories as training schools. The Ministry of Home Affairs was given responsibility for training schools and for providing the necessary finance.
1952	The Training School Rules were authorised under the 1950 Act.
1953	The Prison Act (Northern Ireland) was passed.
1954	A borstal was set up for girls at HMP Armagh.
1956	The borstal moved from Malone Training School to Woburn House, Millisle.
1957	St Patrick's had moved from Milltown to purpose-built accommodation in Glen Road and their buildings were officially opened..
1961	The girls' borstal at HMP Armagh was closed.
1968	The Children and Young Persons Act (Northern Ireland) and the Treatment of Offenders (Northern Ireland) Act were passed. The Malone and Whiteabbey Training Schools (Northern Ireland) Act 1968 was also passed, renaming the Board managing the schools the Rathgael and Whiteabbey Schools Management Board.
	Malone School was closed and Rathgael was opened.
	The Troubles started.
1972	The Northern Ireland Office was established and took over the control of the training school system from the Ministry of Home Affairs.

	The Health and Personal Social Services (Northern Ireland) Order was passed.
1973	The Ministry of Home Affairs became the Department of Health and Social Services, and the Inspectorate was renamed the Social Work Advisory Group.
	Lisnevin Training School opened with a secure assessment unit and a long-term special unit for committed boys.
	At Crumlin Road Prison a Junior Remand Wing was opened, and so "young terrorists" were not sited at Lisnevin.[3]
Nov 1973	Bernard Teggart was abducted from St Patrick's and murdered by the IRA.
1976	HMP Magilligan received some young offenders.
1977	Young male offenders at Magilligan were transferred to the borstal.
	The assessment unit at Lisnevin was moved to Blacks Road as a day assessment unit.
	A purpose-built closed borstal was opened on the Millisle site.
1978	The Treatment of Young Offenders Act (Northern Ireland) 1978 was passed, to introduce a new approach to the management of young offenders.
1979	The Black Report was published.
	Following the 1978 Act, Hydebank Young Offenders Centre opened.
1980	As a result of the opening of Hydebank, both the open and closed borstals at Millisle were shut.
Sept 1980	The special unit at Lisnevin moved to the Millisle site.
1981	The Adolescent Psychological and Research Unit was set up, amalgamating the four psychologists who had previously been attached to individual training schools.[4]
1982	The Sheridan Report was published.

3 LSN 1234.
4 LSN 1241.

1985	Whiteabbey closed and the girls were transferred to Rathgael, which became mixed. This move had been planned, but was accelerated by a fire which severely damaged Whiteabbey.
	The juvenile remand unit at Hydebank Young Offenders Centre was closed, and a secure remand unit was opened at Lisnevin.
	The Hughes Report was published.
	The Social Work Advisory Group was renamed the Social Services Inspectorate and given a brief to inspect, rather than advise.
1986	Females were transferred from HMP Armagh to Mourne House, Maghaberry.
1987	All four training schools were inspected formally.
1988	HMP Armagh was closed.
1989	The reports of the formal inspections of the training schools undertaken in 1987 were published.
Aug 1994	SPT 81 was killed, run over by a car while absconding from St Patrick's.
1995	The Children (Northern Ireland) Order 1995 was passed, enacting some of the Black Report's recommendations, and replacing training schools with juvenile justice centres.
1995	The end of the Inquiry's remit.
1996	St Patrick's closed and became Glenmona Resource Centre.
1998	Rathgael was closed and became Lakeside.

Appendix 2

Industrial schools, reformatories and penal institutions, either in existence or brought into existence in 1922, which admitted children and young people:

Balmoral Industrial School	Belfast Corporation
*Shamrock Lodge Industrial and Reformatory School	Voluntary/charitable
St Patrick's Industrial and Reformatory School, Milltown	Religious
*Nazareth Lodge Industrial School	Voluntary/charitable
*Sacred Heart Industrial and reformatory School, Whiteabbey	Religious
Malone Reformatory School	Belfast Corporation
St Joseph's Industrial and Reformatory School, Middletown	Religious
*St Catherine's Industrial School, Strabane	Religious
*St Michael's Industrial School, Lurgan	Religious
*Hampton House Industrial School, Belfast	Voluntary/charitable
HMP Armagh	
HMP Belfast	

Starred institutions were closed between 1922 and 1950 when industrial schools and reformatories were redesignated as training schools under the Children and Young Persons Act (Northern Ireland) 1950, most of the closures occurring during the 1920s, presumably as a result of rationalisation. Shamrock Lodge continued as an industrial school only.[5]

5 SPT 1602-1603.

Chapter 14:

Module 7 – Rathgael Training School

The History and Role of Rathgael

1 Rathgael was registered as a training school for boys in 1968, but its role was rooted in the earlier history of the reformatory and industrial school system in Northern Ireland, and in particular Balmoral Industrial School, Malone Reformatory and Whiteabbey, a school for girls.[1] It will be noted that account has been taken of changes in social policy and childcare methods in considering the development of Rathgael and in making any criticisms of practice.

2 A former warship, the 'Gibraltar', was used as a training ship from 1872, and it was registered as an industrial school on 15 June 1877 to provide nautical training for over 300 boys so that they had the skills to obtain work at sea. It was moored in Belfast Lough, and when life on board proved unsuited to the care of the younger boys, an additional school was sited at Fox Lodge from 10 January 1884 on Ravenhill Road, Belfast. This school expanded to meet demand, and by 1897 it held 133 boys. To meet the increased requirement for places a site was acquired at Balmoral in September 1897, which opened in November 1897 to replace Fox Lodge. On 13 March 1899 the ship, by now renamed the 'Grampian', was closed and the remaining boys were brought ashore and placed at Balmoral, where a large new wing was added and junior and senior sections were established. The nautical traditions were maintained and it was not until 1934 that naval uniform was abandoned. The school at Balmoral was registered for 350 boys, but actually held as many as 442 boys.[2]

3 Following the implementation of the Children Act 1908, industrial schools were used less and the occupancy of Balmoral dropped. It was taken over by Belfast City Corporation on 30 June 1920, shortly before the partition of Ireland. When Northern Ireland was established in 1922, industrial schools such as Balmoral were re-registered. In 1939, with the outbreak of the Second World War, the school's premises were required as a military hospital, and so Balmoral moved to Shamrock Lodge on the Ballysillan Road, Belfast.[3]

4 Malone was originally established as a reformatory for boys in 1860 managed by a voluntary board. It was modelled on Redhill School, which

1 For a fuller history of Rathgael and its predecessor institutions, see RGL 22202-22246. We are indebted to Campbell Whyte and Lindsay Conway for much of the information describing the running of Rathgael.
2 RGL 22208, 22212, 22195-22196.
3 RGL 22196.

was opened in the eighteenth century, a predecessor of reformatory schools, run by the Royal Philanthropic Society in Surrey.[4] In its earlier years Malone was busy, but occupancy was variable at times. For example, around 1885 magistrates became more reluctant to commit boys for reformatory training, as it still entailed an initial period in prison, and around 1920 there was increased use of probation. After much negotiation, Malone was brought under the control of the Ministry of Home Affairs in 1926 under the Malone Training School Act (Northern Ireland) and in 1927 a borstal wing was opened. This meant that in the period from 1927 to 1968 a large proportion of the staff was drawn from the Prison Service.[5]

5 In 1945 Whiteabbey Reformatory School was certified for girls and a year later it was also certified as an industrial school.

6 In 1950 the Children and Young Persons Act (Northern Ireland) was passed, amalgamating the industrial schools and reformatories as training schools. Therefore Malone, Balmoral and Whiteabbey were registered as training schools. Under section 72 of that Act, a court or the Ministry was obliged, in determining the training school to which a young person should be sent, to select, where practicable, a school for the religious persuasion to which the girl or boy belonged. As Roman Catholic boys attended St Patrick's and girls were placed in St Joseph's, the other three training schools in effect served Protestant children. The Malone and Whiteabbey Training School Act (Northern Ireland) merged Malone and Balmoral training schools in 1956, and the Malone and Whiteabbey Training School Management Board was set up. Temporary accommodation arrangements had to be made pending the opening of the new Rathgael buildings, and there followed an unsettled period when the Malone and Balmoral schools were combined.

7 In July 1956 the borstal wing at Malone was moved to Millisle, and in 1968 the training school was closed.[6] The boys and staff were moved from the combined Malone and Balmoral schools to purpose-built premises at Rathgael. This move marked the beginning of a new era. It was intended to take a more up-to-date progressive approach in the provision of care and education for the boys. There was a programme of staff secondment on qualifying courses in residential childcare in England, which introduced

4 RGL 22220.
5 RGL 22196, 22221-22223.
6 RGL 22197.

the students to different ideas. Housemasters and housemothers were appointed, a wider range of activities was offered, comprehensive assessments were undertaken on admission, and psychiatric support was made available.[7]

8 Lindsay Conway, who was first employed at Rathgael as an assistant housemaster in 1972 said that he and a teacher, Campbell Whyte, considered themselves:

> "to be very much part of a new generation of staff being recruited into Rathgael aimed at developing new approaches and creating a different culture within the Training School sector."[8]

9 Despite the range of new ideas which were introduced, some of the traditional working methods and staff attitudes from the Malone and Balmoral era inevitably lingered for some time. Lindsay Conway wrote:

> "A small percentage of staff felt that their only approach, especially with the senior boys, was to be 'macho'; this resulted in a more regimented approach, with an emphasis on physical activity and a highly competitive regime. Over time this was replaced by a more relational approach to working with young people, and the introduction of marks and the setting of short-term goals."[9]

The change described by Lindsay Conway can be seen in the nature of the evidence provided by the witnesses.

10 Prior to the opening of Lisnevin in 1973, Rathgael was the only training school in Northern Ireland for Protestant boys, although a small number of young people were moved to community homes with education in England when secure accommodation or specialist forms of therapeutic care were required.[10] It was therefore expected to provide for boys with a wide variety of problems and cope with difficult behaviour. Campbell Whyte stated that Rathgael, despite being an open institution:

> "accommodated the most difficult, damaged, disturbed and, in some cases, delinquent children"

from the Protestant communities of Northern Ireland.[11]

7 RGL 22231-22232.
8 RGL 5091.
9 RGL 5094.
10 RGL 5093.
11 RGL 1715.

11 From 1958 to 1985 Rathgael was an all-boys school, but in 1985 Whiteabbey was closed and the girls were transferred to Rathgael, which became mixed. The amalgamation also offered the opportunity for a change to be made from the division between a senior and a junior school to the provision of a justice side for offenders and a care side for non-offenders. This development was therefore the final stage in a process of amalgamation, which saw the functions of Malone, Balmoral and Whiteabbey combined on the one site at Rathgael. The numbers of children and young people requiring this type of residential care had clearly diminished considerably over the previous fifty years.[12]

12 The closure of Whiteabbey and the move to Rathgael had been planned to take effect by 3 June 1985, and measures were taken to reduce the number of girls for transfer. Indeed there were those who argued that all the girls who had been at Whiteabbey should have been discharged from there, so that Rathgael would admit only girls who had had no experience of Whiteabbey. However, the process of transfer was accelerated by a fire in March 1985 which severely damaged Whiteabbey.[13] Consequently, the amalgamation of the two schools was not trouble-free.

13 The ten girls who moved over did not want to be in Rathgael and when they were placed together in one unit there were disruptive and challenging behavioural problems. The girls were then split up between the other units, and they settled down.[14] The Whiteabbey staff also had some difficulty in coming to terms with a different way of doing things, but the two teams were integrated over time.[15] Rathgael continued as a mixed training school for thirteen years from 1985 to 1998, after the end of the Inquiry's remit.

14 In 1995 the Children (Northern Ireland) Order 1995 was passed, enacting some of the Black Report's recommendations, and replacing training schools with juvenile justice centres. In 1998, Rathgael was closed but it continued to serve children and young people as a juvenile justice centre under the name of 'Lakeside', managed by the North Down and Ards Trust[16] It is estimated that between eight and nine thousand children and young people passed through Rathgael between 1968 and 1998.[17]

12 RGL 21685.
13 RGL 5099.
14 RGL 1722.
15 RGL 5099.
16 RGL 22197.
17 RGL 1714.

15 For the purposes of this chapter, the two main periods of concern are the 27 years from 1958 to 1985 when Rathgael was for boys only, and the ten years from 1985 to the end of the Inquiry's remit in 1995 when it was mixed. During this time Rathgael developed from its traditional reformatory and industrial school roots to become, in Campbell Whyte's words, "a more caring and educating establishment."[18]

The Premises

16 Rathgael was sited on the outskirts of Bangor, not far from the A2 to Belfast and thirteen miles from the city. The site, which covered 86 acres, was selected because of its easy access to Belfast, where a large proportion of the boys in the school came from,[19] though public transport access was poor in the immediate vicinity.[20] In planning the buildings, consideration was given to recent developments in the approved school system in England, adapted to meet the differing circumstances in Northern Ireland.[21]

17 There was a senior school and a junior school, with a cut-off point at the age of fifteen. The senior school had 70 places in three house units with a pre-release flat with twenty places, and the junior school had 94 places in four house units providing 80 places and a pre-release unit with fourteen places.[22]

18 The need for specialist units in Northern Ireland had been recognised, but the numbers of children and young people requiring some forms of care were very small. Lindsay Conway was critical of the way that training schools were expected to meet a very wide range of needs on the same premises.[23] To meet Northern Ireland's needs the solution devised in planning Rathgael was to follow the English model of house units, but to create a framework within which house units were divided by age and function, whereby different house units could adopt different approaches.

19 There was also a reception unit, which was able to undertake a five-week assessment of newly admitted boys, covering "educational, social, vocational, medical and, if necessary, psychological and psychiatric"

18 RGL 1717.
19 RGL 22233.
20 RGL 5092.
21 RGL 22233
22 RGL 1716.
23 RGL 5093.

aspects. It also provided for boys who were remanded for only a month, thereby leaving the longer-stay units less disturbed by frequent changes among the resident group.[24] The reception unit consisted of two wings for the seniors and juniors respectively, with shared facilities such as a dining room and a classroom in the centre of the building. There were dormitories of different sizes: for eight boys, six boys, four boys and two for two boys each, making 22 bed spaces in each unit. Staff accommodation was also attached.[25] Two of the other house units were single units, but the remainder were on a similar architectural model to the reception unit, in pairs with some shared facilities and staff housing attached. The units, incidentally, were given names that reflected stages in Rathgael's history, such as 'Gibraltar', 'Grampian', 'Fox Lodge' and 'Shamrock House'.

20 There was a semi-secure intensive care unit with seven places. This provided short-term care for children who were not coping in the open school, with a view to returning children to their house units in the open school. The reasons for placement in this unit included drug or glue addiction and absconding.[26] There were time-out rooms, equipped with secured bed frames, heavy duty mattresses, blankets and restrictions on permitted equipment, so that there were no materials which could be used as weapons or for self-harming.[27]

21 In addition to the intensive care unit there were eight units in all, with the potential therefore to house over 160 boys.[28] Campbell Whyte stated that Rathgael was registered to provide 203 places[29] but the actual number of children and young people resident appears to have fluctuated and the registered number appears to have been treated as a guideline, rather than a fixed ceiling which it was forbidden to breach. Campbell Whyte stated that when he joined Rathgael in 1973 there were about 210 boys on the roll and bunk beds had to be set up in recreation rooms.[30]

22 At the centre of the site was the administration block, which contained a number of general services, such as offices, the laundry, the medical centre, the central kitchen and some staff accommodation.[31] There was also an assembly hall, known as the chapel.[32]

24 RGL 22234.
25 RGL 1715.
26 RGL 1716.
27 RGL 5102-5103.
28 RGL 22235.
29 RGL 1714.
30 RGL 1715.
31 RGL 22235.
32 RGL 1715.

23 There were two other large blocks. The first consisted of the workshops, stores and some classrooms for the senior school. The second held the classrooms for the junior school, which included woodwork and metalwork classrooms; a gymnasium was attached, with a swimming pool nearby. There were also separate playing fields for the juniors and seniors, and additional sports grounds for matches.[33]

24 It has been noted above that staff accommodation was attached to each of the house units. The wives of the housemasters usually acted as housemothers, a development introduced on the new site. In all, there were eighteen staff houses, such that Rathgael formed a community of staff, as well as the boys and girls.[34] This had a number of potential advantages. At a practical level it meant that there were probably colleagues readily available to replace a sick member of staff, to assist in a crisis or to provide transport. On a more general level, the presence of a large number of staff gave scope to create supportive teamwork whereby staff knew that they had the backing of others to whom they could turn if necessary. Resident staff also often identified more closely with the school or home where they worked, and the availability of accommodation may have reduced staff turnover.

25 This brief description omits many of the additional facilities provided, such as equipment for the screening of films in the gymnasium, a pottery, greenhouses, a band room and so on. In short, Rathgael was provided with an excellent range of premises and equipment, equal to the best in the United Kingdom at the time of its construction.

26 There were also two other services for children that came under the control of Rathgael. The first was Runkerry, an outdoor pursuits centre near the Giant's Causeway, which was used not only by Rathgael but by other training schools and services for children and young people.

27 The second was the East Side Project, which offered 24-hour support for young people who had settled in east Belfast following discharge from Rathgael. The scheme offered help in finding work, in developing self-sufficiency and in participating in the community. It went on to take referrals from all over Belfast and had three houses for those who had nowhere else to live. Lindsay Conway said that the concept arose from the Black Report and the proposal was based on research he had undertaken

33 RGL 22235.
34 RGL 22235.

concerning young people with no home base.[35] Campbell Whyte reported that this scheme won a national award in 1984.[36]

The Aims

28 The official aim of the school was:

> "to restore the child or young person to society better equipped mentally and emotionally to cope with the environment from which he came and to accustom him to the habit of work. It is a process of readjustment and social re-education, based on an understanding of the personality, history, abilities and aptitudes of each boy or girl and a knowledge of the family situation, and is promoted by
>
> (a) a stable environment which enables remedial influences to be brought to bear and progressive training to be given;
>
> (b) contact with the home; and
>
> (c) help and supervision after the boy or girl leaves the school."[37] [38]

Daily Life

Care and Justice Sides

29 The two parts of Rathgael were known as the care side and the justice side, and the split reflected the conclusion of the Black Report that young offenders should be dealt with separately from children with acute needs and behaviour problems who were non-offenders. The second group were known colloquially within Rathgael as the 'care bears'.[39] The division was not rigidly observed and some children were moved from one side to the other when it was felt that their needs would be met more appropriately on the other side. HIA 434, for example, was placed on the care side until he was involved in joyriding, when he was moved over to the justice side, which he found "very different", being "treated as if I were a criminal."[40]

35 RGL 5112.
36 RGL 1720.
37 RGL 1715.
38 This quotation is taken from *A Social Psychological Evaluation of a Community Service Programme for Young Offenders in a Northern Ireland Training School*, a thesis by Campbell Whyte, August 1981, pp.30-31.
39 RGL 083.
40 RGL 113.

House Units

30 Each house unit had its own team of staff led by a house warden, comprising housemasters and housemothers, together with teachers and instructors undertaking extraneous duties additional to their teaching role. Houses were encouraged to develop their own character and children were allocated to house units which were thought to match their particular needs.[41] In the reception house on the care side, residents were locked in their dormitories at night and had to call the care staff if they needed to go to the toilet. The other houses were open.[42]

Daily Routine and Education

31 The residents were awoken at 7.30am, and after breakfast at 8.00am there were morning jobs and some free time before school.[43] The school day started with assembly at 9.00am, held in a building called the chapel. The content of assemblies was non-religious and was designed to give the children positive messages, though at least two of the witnesses recalled assemblies as being Catholic services.

32 There was then classwork or work in workshops until lunch, which was served in the house units, followed by more classwork and workshops until about 4.00pm.[44] In the junior school, subjects taught included literacy, mathematics, geography, history and physical education, where possible matching the junior intermediate school curriculum in mainstream schools.

33 Several witnesses spoke about the quality of education provided at Rathgael, and most, but not all, were critical. Among the critics, HIA 200 said that the education was "very basic", such that he had difficulty adjusting when he returned to Bangor High School.[45] HIA 429 said:

> "...school in Rathgael...was like going back to primary school. I have dyslexia and no additional help or assistance was provided. The education was very poor and my level of education fell. For that reason I had more interest in practical subjects like woodwork, gardening and metal work than the academic subjects."[46]

41 RGL 1716.
42 RGL 111.
43 RGL 5103.
44 RGL 1718.
45 RGL 041.
46 RGL 108.

HIA 172 said:

> "If Rathgael was supposed to fulfil a child's educational needs I could never understand why I left Rathgael unable to read and write. I have taught myself everything that I know."[47]

34 HIA 231 said that school work was not compulsory and there were weeks at a time when she did not attend. The classes were of mixed ability, with twelve to fifteen children in a class. She said that her education essentially stopped when she went to Rathgael and she left without any qualifications.[48] Her education report from Rathgael described her as 'very difficult to teach'.[49]

35 HIA 503 said that her:

> "education consisted of colouring in pictures. I was not taught anything of value and I left there without any qualifications."[50]

36 By contrast with the critics, HIA 267 thought the education system was "fairly good" and he learnt to read, though he obtained no qualifications.[51] HIA 434 said that although some of them had short tempers the teaching staff were good to him. He explained that the whole school was put into five streamed classes, with the least able in Form 1 and the "very clever" in Form 5. This meant that the classes had mixed age groups and there was no set curriculum.[52]

37 The PE teacher, RG 17, was described as being good at sport but very strict. He had a real talent for gymnastics and he trained a team of boys from Rathgael to give displays.[53] HIA 267 found him "a positive influence";[54] others were afraid of him. HIA 429 alleged that RG 17 threw him into the swimming pool, which scared the life out of him, but he became a strong swimmer.[55] RG 17 denied having done so, and said it was his target to teach all boys at Rathgael to swim.[56]

38 HIA 172 said that RG 17 walloped him a few times, and that he was quite a violent man who:

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47 RGL 021.
48 RGL 049.
49 RGL 46566.
50 RGL 132.
51 RGL 067.
52 RGL 112.
53 Day 152, p.181.
54 RGL 068.
55 RGL 108.
56 RGL 31323.

> "would slam children into the ground, twist their arms up their backs, use swimming flippers to whack them across the legs and throw things at them."[57]

HIA 429 said that RG 17 hit many boys with the largest plimsoll available at Rathgael.[58] RG 17 denied having done so[59] but several witnesses made mention of the plimsoll, which even had a name, being known as "Rufus".[60] [61]

39 Despite RG 17's denial, he stands out as the member of staff whom the witnesses accuse most frequently of physical abuse, and we accept the allegations that he applied informal corporal punishment which was unrecorded and contrary to the Training School Rules. RG 17 achieved success in Rathgael's sporting activities, nonetheless some of the children were afraid of him. **We consider RG 17's practice of using frequent unrecorded informal corporal punishment unacceptable, amounting to systemic abuse**.

40 In the senior school the main focus was on trade training, with departments to teach building, metalwork, motor engineering, painting, decorating, joinery, catering and horticulture, leading on to City and Guilds awards from the 1980s onwards. HIA 400, for example, completed a City and Guilds in motor engineering.[62] Classwork was optional for seniors.[63] Young people with a high level of academic ability attended local schools in the Bangor area to continue mainstream education and obtain qualifications.[64]

41 HIA 503 said that she had work experience in the kitchens, but that she spent the entire fifteen weeks making sandwiches. When the kitchen staff took their breaks she was locked in the kitchen on her own.[65]

42 At 4.00pm the children and young people returned to their house units for dinner and evening activities. These included classes in photography, art and typing as well as playing pool, table tennis, board games, watching television and doing hairdressing. There were also sporting competitions, mostly for football, pool and gymnastics and Rathgael Gymnastics Club

57 RGL 020-021.
58 Day 152, p.161.
59 RGL 31323.
60 RGL 040.
61 Day 152, p.26.
62 RGL 095.
63 RGL 1717.
64 RGL 5095.
65 RGL 132.

put on displays[66] HIA 200 also mentioned "patter tennis" played on miniature courts.[67] HIA 400 said that each house had to build a raft and they were raced across the lake.[68] These competitive activities appear to have taken place for the most part while Rathgael was for boys only.

43 HIA 503 complained that the residents were not allowed to select which television programme was watched, and that the pool table could only be used on the infrequent occasions that staff could accompany them.[69] Bedtime was at 9.00pm.[70] The nightwatchman had two large Alsatians which he took with him when he patrolled the dormitories.[71]

Activities

44 At weekends there was house cleaning on Saturday mornings, church parades in Bangor Protestant churches on Sunday mornings, and Sunday services conducted by chaplains on Sunday afternoons. HIA 429 said that there was always something planned for them to do at weekends, such as walks, swimming or videos. He joined the cycling club and was allowed to cycle home to stay with his father in Belfast.[72] In general, though, there was more free time.

45 Campbell Whyte also described a Community Service Programme, which he initiated in 1974. Young people were placed in a variety of community-based programmes (Rudolf Steiner, PHAB, and the Avoca Play Group, for example) where they took on the role of 'treaters' rather than being treated themselves. Over 150 boys participated in the first five-and-a-half-years, with minimal trouble.[73]

Health Care

46 There was a matron and two qualified nurses to provide 24-hour first aid cover, there were daily 'sick bay parades', a doctor visited weekly, and dental care was available on site.[74] When the girls from Whiteabbey joined Rathgael, a female doctor was also appointed.[75] The sick bay facilities were replaced in the 1980s by care provided by nurses visiting the house units.

66 RGL 1720, 1721.
67 RGL 041.
68 RGL 096.
69 RGL 130.
70 RGL 5103.
71 RGL 066.
72 RGL 108.
73 RGL 1719.
74 RGL 1721.
75 RGL 5096.

47 A number of witnesses were critical of the health care which they received. HIA 200 wrote:

> "There was no medical or dental care. There was a Matron ... but she just seemed to dispense Strepsils for every ailment."

Although medical investigations had identified a minor degree of cerebral palsy among other things when she was little, HIA 198 said that she was not given any medication or medical help at Rathgael.[76]

48 HIA 438 suffered appendicitis at a weekend, and at first was only given paracetamol by a locum doctor. When examined by Rathgael's own doctor on Monday after a weekend of agony, she was admitted to hospital for emergency surgery.[77]

49 HIA 182 said that ambulances were never called when children self-harmed as the staff did not want to draw attention to Rathgael. Instead, RG 11, who was a senior member of staff resident on site, was to be called.[78] RG 11 agreed that he might be called at night, depending upon the severity of the self-harming but denied that he would fail to call an ambulance or take a child to hospital if that was required.[79]

50 When HIA 438 had her first period she absconded to talk to her mother, and when she was returned to Rathgael she was put in isolation, and no one talked to her about the changes that were happening to her body.[80]

51 Staff found out that HIA 434 was having a consensual relationship with a girl at Rathgael, and he was required to attend the VD clinic every three weeks for about three months before he was informed that he was disease-free. He was then given sex education and some condoms.[81] He said he felt humiliated by this treatment, but we consider that the staff were taking sensible precautions.[82]

Clothing

52 In the earlier years, residents were required to wear a uniform but from the early 1980s they wore their own clothes.[83] HIA 172 said that his own

76 RGL 034.
77 RGL 120.
78 RGL 025.
79 RGL 4824-4825.
80 RGL 120.
81 RGL 114.
82 Day 153, p.135.
83 RGL 1721.

clothes were removed on admission in 1986, and they were all made to wear outdated humiliating clothes which marked them out as being from Rathgael when they were in Bangor.[84]

Food

53 Food was cooked in a central kitchen, but children ate in their own house units. HIA 267 thought the food was good[85] but HIA 386 and HIA 389 were both critical of the food, alleging that they were forced to eat undercooked meat, and as a consequence they both became vegetarians despite being provided with the same vegetarian dish every day.[86] HIA 503 also complained of the lack of choice for vegetarians.[87] HIA 198 described the food as disgusting and unfit for human consumption; the meals reaching Shamrock House were cold and rubbery.[88] HIA 83 said that the food was "horrible and watery", and that they had to drink from "a plastic cup and eat off plastic plates".[89]

54 From a staff perspective Campbell Whyte noted that there were complaints about the food in the 1970s and early 1980s, but measures were taken to improve the food and the chef was replaced.[90]

55 Most of the complaints quoted above concerning education, health care, food and other aspects of daily living relate to the period from 1985 to 1995 when Rathgael served both boys and girls. While some of the complaints may well have been justified and represented instances of poor childcare, we do not consider any of them to have amounted to systemic abuse, with the exception of RG 17's informal use of corporal punishment.

Family Contact

56 Visits by the residents' families were permitted, but the siting of Rathgael made visiting difficult for those who lived in parts of the province away from Belfast.[91] HIA 200's father visited him every week, but his mother had moved to Portrush and she visited less frequently as the journey was difficult.[92] HIA 400 was visited regularly by his mother, but his father was

84 RGL 015.
85 RGL 066.
86 RGL 082-083, 091.
87 RGL 129.
88 RGL 034.
89 RGL 003.
90 RGL 1721.
91 RGL 5092.
92 RGL 041.

an alcoholic and HIA 400 was "not sure he was even aware I was in any institution".[93] HIA 386 said she never had visitors, but she put that down to lack of interest on the part of her parents.[94] HIA 231 was visited weekly by her grandmother, whom she saw as the only positive influence in her life at that time, but she did not feel able to disclose the sexual abuse she was suffering to her grandmother, who was in her mid-seventies.[95]

57 Some of the witnesses had siblings and cousins who were also in Rathgael at the same time, but sometimes living in other units. HIA 503 said that when her brother was gravely ill she only learnt of it from her sister, who was in the care side. She was not allowed to visit him in hospital. When another brother visited and brought her a television, he was not allowed to see her, as he had not made an appointment, and she was not permitted to have the TV set.[96] When she spoke to a brother on the phone, HIA 503 was told that their conversations were not appropriate, and this resulted in her "pushing him away and rejecting contact with him", which she believed was a deliberate tactic to alienate her from her family.[97]

58 Residents had home leave, depending upon their progress in the school,[98] but children and young people had long journeys on their own if they lived some distance away.[99] Residents assessed as being eligible for leave were granted two-week blocks of time at home, and during this time staff from the house unit visited to monitor progress.[100] We consider the arrangements for family contact to have been broadly satisfactory.

Absconding

59 Absconding was a serious problem at Rathgael. The school was not a closed institution; it was not far from Belfast and the main road went near the school, so that absconding was fairly easy for any boy or girl wishing to run away. Absconding put children at risk as they could become involved in offending while on the run, and they were vulnerable to exploitation and danger, particularly during the Troubles.[101]

93 RGL 096.
94 RGL 085.
95 RGL 048.
96 RGL 131.
97 RGL 132.
98 RGL 1722.
99 RGL 5092.
100 RGL 5104.
101 A fuller description of problems associated with absconding and details of research findings are to be found in chapter 12 on St Patrick's Training School.

60 Lindsay Conway stated that:

> "no child would have willingly chosen to come to Rathgael, although many knew that there was no other option."[102]

He felt that absconding was triggered at times by external factors such as a wish to see a relative in hospital, but in other cases it was to avoid bullying by other residents or perceived mistreatment.[103] It is not surprising, therefore, that a substantial number chose to run away.

61 Campbell Whyte wrote:

> "Every time a young person absconded, this was reported to the local police. Rathgael received a lot of criticism because of the high level of absconding. In response to criticism by the North Down MP Jim Kilfedder, the *Spectator* newspaper ran an article on the school on 22 September 1991. Statistics at the time of the article in relation to absconding showed that in the previous six months, 54% had not absconded; 34% had absconded but many were just late back from home leave, a training programme or work, whilst some were absent for a day or two; only 12% were persistent and serious absconders - these were the cause of most concern."[104]

62 Caning was administered by the head or his deputy,[105] and this would appear to have been the way in which absconding was dealt with in earlier decades. In 1977 boys were put into corduroy shorts and baseball boots with no laces to prevent absconding.[106] [107] HIA 200 said that the police usually caught absconders quite quickly.

> "The staff would isolate you for a time after you were returned and you were made to wear shorts instead of jeans. The boys who ran away were closely supervised by a housemaster after they were caught."[108]

HIA 434 said that when he had absconded he was left for ten to fourteen days in an isolation room in his underwear, with a plastic mattress and a sheet. He was brought food on a tray three times a day, but was otherwise left isolated.[109] His records show that HIA 434 absconded on seventeen

102 RGL 5094.
103 RGL 5099.
104 RGL 1724.
105 Day 152, p.81.
106 RGL 003.
107 Day 152, p.75.
108 RGL 041.
109 RGL 112.

occasions, but there is no reference to the lengthy spell in isolation which he alleged.[110]

63 Because of the scale of the problem, the Adolescent Psychology Research Unit (APRU) was commissioned to carry out a review in 1991, which criticised the failure to monitor absconding. A Monitoring Group was set up therefore "to monitor, understand and reduce absconding." There were follow-up reports in 1992 and 1993. In 1992 it was noted that:

> "The number of absconders and number of abscondings in the Rathgael Centre has declined significantly in both absolute and proportionate terms. The number of absconders is reduced by 37%; the number of abscondings is reduced by 60%. This is attributable to the strategic management approach implemented by Senior Management. Given the inherent unpredictability and fluctuating nature of absconding the difficulty in sustaining this reduction should not be underestimated."

64 Action was taken to address this problem:

> "The young people were counselled on the likely consequences of absconding, and sanctions, such as depriving them of taking part in activities or freedom of movement were applied. In addition a number of measures were in place to reduce absconding in relation to:
>
> - carrying out detailed research to ensure improvements, if any, could be measured;
> - provision of a residential programme for homeless children outside North Down; and
> - and continuation of work on providing a semi-secure building to enable the more serious absconders to be locked in their rooms at night."[111]

65 The number of abscondings increased again in 1993, probably in part because of a 25% increase in admissions. The significant point as far as this Inquiry is concerned, however, is that Rathgael management recognised the seriousness of the problem and took sensible measures to address it.

110 RGL 994-99.
111 RGL 1724.

The Management of Difficult Behaviour

Corporal Punishment

66 In the early years, caning was still permitted, subject to the Training School Rules, but Campbell Whyte, who joined the staff in 1974, said that he never witnessed or administered corporal punishment. When corporal punishment was abolished in state schools under the Education (Corporal Punishment) (Northern Ireland) Order 1987 a Directive was issued concerning training schools and the practice stopped.

Points Systems

67 Campbell Whyte reported that "There was very little violence in Rathgael and none against staff until the last few years".[112] RG 24, however, said that "both verbal and physical assaults on staff [were] not uncommon"[113] and cited extracts from board minutes.[114] When a pupil was disruptive in the classroom, 'contracting' was introduced, whereby an agreement was made with the pupil to earn points for improved behaviour.[115]

68 There was also a points system to reinforce good behaviour. Marks were allocated by staff for good behaviour in class and in the house unit and for performance at school or in the workshops, for house-cleaning and for tidiness of rooms, as well as sporting activities. There were weekly 'Mentions Meetings' to discuss children's conduct and small monetary rewards were given.[116] High scores were rewarded with:

> "…full pocket money, full home leave and full participation in sporting and weekend activities."[117]

Negative scores could result in sanctions such as:

> "…reduction of pocket money, withdrawal of home leave, withdrawal of sporting activity and early beds."[118]

The Mentions Meetings were attended by all the residents and the house staff, and were held on Friday afternoons; they were also used to discuss activities for the weekend and routine matters concerning the house unit.

112 RGL 1717.
113 RGL 5098.
114 RGL 22790-22797.
115 RGL 1718.
116 RGL 1723.
117 RGL 5104.
118 RGL 5104.

Sanctions

69 Sanctions were based on the withdrawal of privileges such as pocket money, television, swimming trips, home leave and outings.[119] Campbell Whyte nonetheless acknowledged that:

> "There is no doubt that there was a difficulty in getting the balance right between care and control."[120]

70 Rather than deprive the residents of cigarettes completely, RG 5 chose to cut their cigarettes shorter, "At times…shortened to an inch long". HIA 503 said that this led to tensions among the residents, as any confiscated cigarettes were usually returned later on, while the parts of the cigarettes which were cut off were destroyed, which was resented.[121] [122]

71 HIA 267 said that, as a punishment, boys were given small hammers to chip tiles away from a swimming pool. Their hands were blistered and they had no protection against the dust. He considered this a degrading form of child labour.[123]

Close Supervision

72 Campbell Whyte reported that he was aware of three suicide attempts, though none were successful due to the vigilance of the night supervisors. There were other instances of self-harm through children cutting themselves or swallowing glass. To address this problem, Campbell Whyte set up a Self-Injury Monitoring Group which met monthly, monitored patterns of behaviour and considered any practical measures required, such as closer supervision.[124] Children and young people who self-harmed were often transferred to Shamrock House or Fox Lodge where such behaviour was more easily monitored and managed, with the close support of the APRU.[125]

Restraint and Isolation

73 In the event of difficult behaviour, young people were frequently restrained and placed in secure rooms, such as the Shamrock Room. HIA 503 wrote:

> "In my room at Rathgael there was no handle on the inside of my

119 RGL 1723-1724.
120 RGL 1717.
121 RGL 130.
122 Day 155, p.108.
123 RGL 066.
124 RGL 1726.
125 RGL 5110.

door, which was locked at night. There was a glass window in the door and staff would peer through this at night when I was in bed. We had buzzers in our room that we had to ring for staff to accompany us to the bathroom. I have always suffered from a weak bladder and would have to urinate frequently. When I would press the buzzer, staff would ignore it and I would have had to urinate in a container and dispose of the contents out the window. In place of a mattress I had a blue gymnastic mat. I had no bed sheet to cover the mat. I had one thin blanket and a pillow. During the winter months I was very cold."[126]

74 HIA 503 was critical of the use of isolation, seeing it as pointless and inhuman; she argued that it did not solve children's problems and that staff needed to talk to the residents, rather than shut them away.[127] HIA 198 endorsed HIA 503's description. Young people in Shamrock House had to ask to go to the toilet and they were accompanied by a member of staff. During the daytime they had to remain in one room, watching television together, and they were never allowed to be on their own. Bedroom doors were locked at night time.[128] They attended school, but were limited to colouring in pictures, completing crosswords and playing games on the computer.[129] In oral evidence she said that they were just sitting around doing nothing.[130]

Discharge

75 The ultimate sanction if Rathgael staff could not manage a young person's behaviour was removal to Millisle borstal or, later on, the Young Offenders Centre. This entailed endorsement by the NIO and an order signed by a lay magistrate. Campbell Whyte recalled two such instances.[131]

Case Management

76 Some children and young people were admitted to Rathgael in the first place as they required care because of a crisis in their personal or family life; this was often on a short-term or interim basis. Others were placed at Rathgael because of their offending. As noted above, these two groups were dealt with separately in the care and justice sides of Rathgael respectively.

126 RGL 129.
127 Day 155, p.91.
128 RGL 033.
129 RGL 034.
130 Day 155, p.72.
131 RGL 1727.

77 In each side, children were admitted to reception houses so that their needs could be assessed before being moved on to other units. In 1982 Campbell Whyte introduced Independent Assessment Treatment Profiles as a mechanism to develop an interdisciplinary approach to deal with the particular problems of individual residents, and he said it was deemed successful.[132]

78 Following assessment, residents' progress was observed and monitored. Staff were provided with sheets which gave them the information they required for the coming day or night, and they recorded any events that occurred on these sheets. If there were incidents, an additional form was completed, and if an incident was serious, it was drawn to the attention of senior staff.[133]

79 In Campbell Whyte's time, members of the Adolescent Psychological Research Unit visited Rathgael every day, and Dr Clenaghan, a psychiatrist, visited the school weekly.[134]

80 Lindsay Conway noted that when Training School Orders were made, the requirements were inflexible and some young people regressed after their first year at Rathgael because of uncertainty about their future placements.[135]

Discharge and Aftercare

81 Under the Training School Rules, it was a requirement that schools should provide aftercare. The discharge of residents related to the progress they had made and Rathgael Management Committee had a sub-committee which monitored the progress of boys and girls and decided when they should be released on licence. The licence was for a minimum of a year but, in accordance with a formula, it might have lasted up to nearly three years. The school was required to find appropriate accommodation (such as the child's family, boarding out, approved landladies or supported housing) and an occupation (return to mainstream education if young, higher education, supervised work placements or employment).[136]

132 RGL 1719.
133 RGL 5106.
134 RGL 1718.
135 RGL 5092.
136 RGL 1728.

82 An aftercare team was established, which evolved into a small community care department responsible for the oversight of aftercare of young people who had left Rathgael. Social workers were introduced to residents at an early stage and they then followed them through to discharge and during their aftercare on licence. The social workers provided support and supervision; liaison with schools; help with employment and work schemes; links with social services and probation; and the provision of reports to other agencies and courts.[137]

83 Witnesses provided very little information about the aftercare which they received. HIA 200 spoke appreciatively of the aftercare provided by RG 18 in his own time; he not only visited HIA 200 but also bought him hampers. Lindsay Conway, a senior member of staff, visited HIA 200 to check that all was going well, and he also attended court to support him.[138]

84 The East Side Project mentioned above, provided accommodation for young people who had no families to whom they could return, and this type of provision was expanded to include units in other parts of Belfast. In short, although the evidence is limited, it would seem that Rathgael fulfilled its aftercare obligations well.

85 HIA 268 said that one of her friends, RG 37, told staff that she did not want to return to her grandparents when discharged as she was being abused. She alleged that staff ignored this and on her first weekend home RG 37 took her own life.[139] A detailed report explains the work undertaken with RG 37 in the months prior to her death. She had earlier been subject to severe mood swings, but was apparently contented and positive about moving to live with her grandparents, and her suicide was a shock to all who knew her.[140] We accept the findings of the report and do not believe that there are grounds for criticising Rathgael.

Staffing

86 No information is available concerning staffing during Rathgael's earlier decades, but the information provided concerning the later years suggests that staffing numbers and training were satisfactory. Campbell Whyte stated that all the teachers were qualified, and that the care staff held either the Certificate of Qualification in Social Work or the Certificate

137 RGL 1720, RGL 5111, RGL 23888.
138 Day 152, p.44.
139 RGL 074.
140 RGL 28162-28164.

of Social Services. Such a level of professionally qualified staff would have been outstanding at that time. When unqualified staff with relevant experience were appointed they had to give a commitment to become qualified within five years.[141] Staff were also funded to attend local and national conferences.[142]

87 As noted above, many of the house staff were married couples, but in 1975 there were two male staff in every house unit.[143]

88 By contrast with the day care staff, night supervisors were unqualified. Campbell Whyte reported that the Inspectorate was keen to remove these staff and introduce qualified staff sleeping in on call.[144] This change was resisted, as waking supervision was necessary and the task of the night staff in relation to the children and young people was relatively straightforward and did not require the professional skills taught on CQSW or CSS courses. Furthermore, Campbell Whyte said that as Director he was contactable out of hours if there were problems.[145]

89 Lindsay Conway commented on the significant role played by chaplains, who provided pastoral care to young people and staff alike.[146]

Complaints

90 There was a complaints procedure in Campbell Whyte's time. Less serious issues were dealt with at house unit level by keyworkers and team leaders.[147] Staff were instructed to report more serious complaints by any of the residents to line management. If there were reasonable grounds for suspecting abuse, the issue was routinely reported to the local police, NIO and Rathgael Board of Management.[148] The member of staff was placed on precautionary suspension as "…the welfare…of the children was of primary importance."[149]

141 RGL 1721.
142 RGL 1725.
143 Day 152, p.61.
144 RGL 1726.
145 RGL 1722.
146 RGL 5095.
147 RGL 1727.
148 RGL 1718 and RGL 46333.
149 RGL 1727.

Governance

91 Reformatories and industrial schools came under the purview of the Ministry of Home Affairs (MoHA), though all of Rathgael's predecessor establishments were run by voluntary boards. From the implementation of the Children and Young Persons Act (Northern Ireland) 1950 they all became training schools, but responsibility for funding and inspection remained with the MoHA. With the implementation of the Malone and Whiteabbey Training School Act (Northern Ireland) in 1956 the MoHA took over direct control of the three training schools. From 1972 to the end of the Inquiry's remit in 1995 the Northern Ireland Office took over responsibility from the MoHA, which had by now become the Department of Health and Social Services following the implementation of the Health and Personal Social Services (Northern Ireland) Order 1972. The Social Work Advisory Group (SWAG), which came under the DHSS, still provided professional support and advice to training schools by an informal arrangement with the NIO, which eventually became contractual. This role continued when SWAG was redesignated the Social Services Inspectorate, with a more rigorous inspectorial function.

92 Throughout its existence, Rathgael had a close working relationship with its host Government Departments and in particular the section responsible for support and inspection. Lindsay Conway wrote that the working relations between the Management Board, the NIO and the other training schools were good, with:

> "a familiarity and openness that enabled positive working, whilst allowing challenges to be made when appropriate."[150]

Contact with the Social Work Advisory Group, and later the Social Services Inspectorate, was frequent, offering ready access to advice.[151]

93 Rathgael was under the control of a Management Board which was answerable to the Ministry of Home Affairs, and later to the NIO. Members were appointed by the Secretary of State for three-year terms, with a maximum of two terms allowed. Board membership consisted of a cross-section of the community:

> "including clergymen, councillors, trade union representatives and independent individuals with an interest in youth care."[152]

150 RGL 5107.
151 RGL 5107.
152 RGL 5107.

94 The Board met monthly and had three main sub-committees, dealing with finance and property, the review of children's progress in accordance with the requirements of the Training School Rules, and staffing matters respectively.[153] Sub-committees were also set up to deal with specific issues, either concerning ongoing matters such as the management of the Runkerry site, or topical issues such as the high levels of stress and staff sickness experienced in 1984 following the integration of Whiteabbey and Rathgael.[154] Board members visited the school on a monthly basis, interacting with both staff and residents, and recording their visits in detail. The Board also had oversight of the implementation of innovative thinking.[155]

95 The Director reported monthly to the NIO, covering disciplinary matters and issues which might attract publicity, including any allegations of abuse. Campbell Whyte said that he and his management team devised a five-year business plan, which was presented to the Deputy Under-Secretary at the NIO, and thereafter he reported annually against the targets laid out.[156]

Finance

96 Finance for Rathgael was "adequate, perhaps generous" in the early days.[157] However, during the 1980s there were budget cuts. The senior management team, which was top-heavy, was reduced by 50% and twenty staff from the departments were made redundant, resulting in the closure of the painting and brick-laying workshops. With the exception of this cost-cutting exercise there is no indication in the records that shortage of finance affected the quality of services provided.

Inspections

97 As with other training schools, the Ministry of Home Affairs was for many years responsible for the inspection of Rathgael. There were inspectors on its staff, though it did not have an inspectorate as such. In 1973 the childcare responsibilities of MoHA were absorbed by the Department of Health and Social Services. Under the DHSS the Social Work Advisory Group was set up with its own management structure. From 1973 the

153 RGL 5108.
154 RGL 5098.
155 RGL 5108.
156 RGL 1723.
157 RGL 1725.

NIO was responsible for running and inspecting training schools but it made an arrangement with the SWAG to undertake the inspections; this arrangement was at first informal and later contractual. There was then a phase when the Social Work Advisory Group took on a less inspectorial role, offering advice and support instead of formal inspections. A more rigorous inspectorial regime was introduced in 1986 under the influence of the Hughes Inquiry, and SWAG was renamed the Social Services Inspectorate.

98 Only one inspection report concerning Rathgael is extant, dating to 1987. The inspection was undertaken as part of a programme of inspection involving all training schools in the wake of the Hughes Inquiry. The inspection covered two and half weeks and involved four inspectors, headed by Dr Kevin McCoy. The report indicates a thorough examination of the school and 74 recommendations were made for improvements.[158] Many of these were practical matters or recommended the review of various systems, but several related to locking up children and recommended a more liberal approach. The report recognised the massive changes which Rathgael had undergone in the previous four years, with the introduction of girls and the care/justice split. The lead criticism, however, related to the provision of information to residents and their families, and in particular to their opportunities to make complaints.

99 An inspection of Shamrock House Intensive Care Unit was undertaken in 1992 at the request of the Northern Ireland Office as part of a thematic review of secure accommodation and intensive care units, in the wake of the Pindown Report, to seek reassurances that children's rights were being observed and that the practices in Staffordshire were not replicated in Northern Ireland.[159] A team of three inspectors led by Victor McElfatrick visited the Unit from 22 to 23 January 1992. They made nine recommendations, the main concerns being the poor maintenance of the bedrooms and the need for a second senior residential social worker to provide consistent cover, particularly in view of the number of casual staff. Of the permanent staff, four had relevant qualifications and three were unqualified, but were required to train during their first five years in post. Overall, the description of the policies, systems and resources in the unit suggested a well-run professional operation.[160]

158 RGL 23626-23752.
159 *The Pindown Experience and the Protection of Children*, (1991) by Alan Levy and Barbara Kahan.
160 RGL 23798-23833.

100 Otherwise, we have no evidence that other inspections were not carried out as required, but if so the records are no longer extant, having probably been destroyed in accordance with departmental file disposal policy. There are no records of the annual training school inspections which might have been anticipated from the opening of Rathgael in 1958 to 1973. It seems highly likely that no inspections were undertaken from 1973 to 1987, as this was the pattern in other training schools during the period when SWAG offered advice and support but did not undertake inspections. It appears that inspectors visited informally and that their advice was appreciated, and the DoH have said that such visits involved the "scrutiny of practice", though we have received no evidence of the content of such meetings or their impact on practice. The evidence of inspections from 1987 onwards has been reported above. **We consider NIO's failure to ensure that Rathgael was inspected from 1973 to 1987 to have been systemic.**

The Evidence

101 The witnesses who gave evidence to the Inquiry concerning Rathgael gave evidence in Module 7. Following an introduction by Senior Counsel on 19 October 2015, eighteen applicants gave evidence, together with two senior members of staff and Dr Hilary Harrison who represented two core participants, the Department of Justice and the Department of Health, Social Services and Public Safety, which had prepared a joint statement.[161]

102 Eighteen applicants to the Inquiry had been resident in Rathgael and it was these people who gave both written and oral evidence. In addition, we received information concerning 40 former residents who made complaints to the police, making 58 who alleged abuse. With one important exception, the patterns of abuse alleged to the police were similar to those of the applicants to the Inquiry. None of the applicants had attended Balmoral School. One witness was resident in Whiteabbey School prior to moving to Rathgael. Two witnesses had attended Malone School, but their main concerns however, had related to other residential establishments and they did not give evidence in this module.

103 The 58 complainants fall into two fairly distinct groups: the 23 admitted during the first phase between 1968 and 1985 when there were only boys at Rathgael, and the 35 admitted during the second phase from 1985 to the end of our remit in 1995, who were a mixture of boys and girls.

161 RGL 1332-1334.

104 Not only did the nature of Rathgael change with the arrival of the girls and staff from Whiteabbey, but so did the nature of the allegations put forward both by applicants and by those who gave evidence to the police. These two phases will therefore be considered separately. Because those who spoke to the police did not give evidence to the Inquiry in person, we have considered the information drawn from their records primarily as confirmatory, and the accounts of alleged abuse in this chapter are based almost entirely on the oral and written evidence of witnesses. Two people who were in Rathgael from 1995 onwards made allegations but they were not considered, as this period was beyond the Inquiry's Terms of Reference.

105 Six applicants were resident during the seventeen years when the school was for boys only from 1968 to 1985, and twelve (eight of whom were girls) were there during the ten years from 1985 to 1995 when it was a mixed establishment. The number of witnesses making allegations was therefore substantially higher during the second phase. Considering the size of the school and the estimated total throughput of about seven to eight thousand children and young people, the number of applicants and other complainants alleging abuse is moderate, and in the early years, in a school accommodating 200 or more pupils, it amounts to little more than one a year. This is not to diminish the seriousness of the evidence of abuse provided by the witnesses, but it has a bearing on the question whether the alleged abuse was systemic.

106 During the 1968 to 1985 phase, in the evidence of the applicants there was a clear emphasis on physical abuse, perhaps in part reflecting the tough traditional regime inherited from Malone Training School. However, those who complained to the police made allegations as much about sexual abuse as physical abuse; this is the only instance in which the picture presented by the applicants' evidence differs from that of people who spoke to the police. There were also some complaints of emotional abuse made by applicants who were at Rathgael in the first phase.

107 During the 1985 to 1995 phase there were 26 female complainants and nine males. Of these, there were nineteen females who alleged sexual abuse, but only one male. This is clearly a radically different pattern from the earlier period. Whatever sexual abuse of boys there had been previously, it seems to have diminished considerably, while the sexual abuse of the girls became a major issue.

108 Four of the female complainants were admitted around the time when Whiteabbey joined Rathgael and they alleged sexual and physical abuse. The one male who alleged sexual abuse was also admitted about this time. There were also three males who alleged physical abuse and one who alleged emotional abuse.

109 Thereafter, only three males made allegations, which all concerned physical abuse. There were, however, 22 female complainants, who made allegations concerning a mixture of sexual, physical and other forms of abuse. In particular, from 1992 to 1995 there were fifteen complainants, ten of whom alleged sexual abuse. Since many of the residents stayed at Rathgael three or four years, this means that at this time there were always about half a dozen girls in the school who have subsequently alleged sexual abuse. Nor does this figure include any who were abused but who have chosen to speak to neither the police nor the Inquiry.

110 In view of the emphasis on sexual abuse allegations in 1985 to 1995 it is perhaps surprising that the number of complaints of physical abuse by former girl residents is approximately equal to the number of allegations about sexual abuse, because of complaints about excessive restraint. Physical abuse was also the main concern of the boys, though the complainants were far fewer in number. In all, allegations of physical abuse amounted to more than a third of the complaints.

111 Six boys and six girls alleged emotional abuse. It is not clear whether this reflected a higher level of emotional abuse than in other homes, or whether it indicates a greater awareness of emotional issues among former Rathgael residents, reflecting the type of therapeutic discussion they may have had with staff.

112 Nearly all the allegations classed as 'other' relate to the 1985 to 1995 phase. They include single allegations of disproportionate punishment, neglect, inappropriate behaviour and threatening with a gun, and two of false imprisonment. These allegations did not suggest any systemic patterns. The one significant feature is that eight people (six women and two men) alleged failure to report abuse.

113 The reasons for the increase in allegations in the second phase are not clear. Fewer witnesses will presumably have come forward from earlier years because of age and infirmity, but it may also be that younger adults are more prepared to complain, when in previous generations people were more accepting of harsher conditions or poor standards of care. Again,

it could be that the style of residential childcare at Rathgael encouraged young people to speak up. It is equally possible that there were more instances of abuse in the later phase.

Allegations of Abuse

Phase 1 (1958 to 1985): Allegations of Physical Abuse by Staff

114 During the phase when Rathgael was for boys only, one applicant made no complaint about the school; the remaining five all complained primarily about physical abuse.

115 HIA 200 provided a good example of the range of physical abuse which he alleged. He named five staff as people who had physically assaulted him in the sixteen months he spent at Rathgael. RG 13 was "quite violent" and was always shouting at the boys. When HIA 200 was caught lying, RG 13 slapped him round the head and face, to the point that a young female member of staff tried to intervene.[162] RG 16 insisted that the boys all jumped into the sea, and when HIA 200's twin brother refused, RG 16 threw him in.[163] RG 16 also hit HIA 200 round the face and head when he refused to change into the school uniform on re-admission; HIA 200 absconded in consequence, and when he was picked up from his home, RG 16 apologised to him. RG 73 punched HIA 200 in the stomach when he caught him doing something wrong.[164] Finally, as mentioned earlier, HIA 200 saw RG 17, the PE teacher, as a bully who used his slipper for beating boys for minor misdemeanours.

116 In summary, HIA 200 saw this kind of punishment as "normalised to a degree" in Rathgael.[165] There were other staff to whom he could talk, and HIA 200 named three whom he rated highly, but even they did nothing if he complained of bullying.[166] He concluded:

> "I experienced a lot of physical, emotional and verbal abuse at Rathgael both from the other boys and from staff members."[167]

and he remembered his time in Rathgael as:

> "an almost entirely negative experience."[168]

162 RGL 038.
163 RGL 038.
164 RGL 039.
165 RGL 040.
166 RGL 041.
167 RGL 037.
168 RGL 041.

117 Other witnesses gave similar accounts. HIA 248 said that there were no problems while he was in the Reception House, but on moving to House 5 he was physically abused by the housemaster, RG 30, who was known as 'the Beast'. HIA 248 said that RG 30 hit boys on the head with his keys, he kicked them and he punched them. He also punished boys in other ways, making them stand in corners for hours, sending them to bed early without supper or not allowing them to watch television.[169]

118 HIA 248 went to RG 112, the headmaster, and asked for a transfer to House 7, where he was treated well by the housemaster, RG 64, but he says he was later moved to House 8, where the regime was tougher, and the housemaster punched and slapped boys for misbehaviour or on their return from absconding; their privileges were also withdrawn and they were made to wear shorts.[170] The records indicate that HIA 248 frequently presented difficult behaviour, including several abscondings, for which he was at times punished.[171]

119 HIA 434 recalled witnessing RG 20 restraining RG 77 by twisting his hands behind his back and repeatedly punching him in the back.[172]

120 On his first evening at Rathgael HIA 267 was punched by another boy and when he punched him back (RG 50) pulled him out of the queue and beat him with his fists, leaving HIA 267 "very fearful". He found RG 64, who taught him English, very unpredictable and sadistic, delivering "some vicious beatings to the boys he was teaching", knocking one boy unconscious. HIA 267 was "terrified" of him, and on one occasion when RG 64 was beating him, he fell against a radiator and cut his head. He was so upset that he absconded and on his return RG 4, who was known as 'the Tank', gave him a beating.[173] He was beaten on another occasion by RG 4 with such force that the cane broke and he thumped HIA 267 with his fists.[174] RG 4 denied that he beat boys in this way, but said that if a boy had to be caned he followed the regulations.[175]

169 RGL 060.
170 RGL 060, 42953.
171 RGL 828, 42957.
172 RGL 111-112.
173 RGL 065.
174 RGL 066.
175 RGL 4777-4778.

121 HIA 267 said:

> "I came to lose respect for all authority figures because of the experiences I had in Rathgael. I believe that, because I saw these violent encounters as a young man, I turned into a very, very violent man myself. It ruined me in the end. Even now, as an adult, I don't back down from a fight, not even if paramilitaries are involved. Consequently, as an adult, I was stabbed twice and sustained other serious injuries, including injuries where someone tried to cut my head off. I feel I have lost almost everything positive in my life because of my exposure to violence."[176]

122 It is clear from the evidence that during the first phase there were some staff who used informal physical violence in order to maintain control and punish boys. It appears to have been used as a response to misbehaviour on the part of the boys, but it was unrecorded and was contrary to the types of corporal punishment authorised in the Training School Rules. There were also staff who did not assault boys physically, but their influence did not prevent their colleagues from breaching the regulations. The practices may well have been part of the historical legacy from the way in which Malone School was run, and it has to be acknowledged that many parents and schoolteachers in the wider community used corporal punishment at this time. Indeed, the Training School Rules permitted caning, but were drawn up in part to ensure that there was no unregulated or unrecorded punishment of this type. We accept that some of the witnesses lived a life of fear as a result of the practices described. **We consider that the extent of the unregulated physical punishment applied by some staff amounted to systemic abuse**.

Phase 1 (1958 to 1985): Allegation of Sexual Abuse by Staff

123 HIA 83 was the only applicant to allege sexual abuse during the 1958 to 1985 period when there were only boys at Rathgael. He said that he was told to have a shower and that a member of staff, RG 31, started to touch his private parts while he was in the shower. A few weeks later he was sent to bed early as a punishment for smoking, and RG 31 entered the bedroom and touched and rubbed HIA 83 while masturbating himself. He added that RG 31 was there every time he went for a shower. HIA 83 said he felt dirty.[177] HIA 83 was discharged and when he was readmitted six months later, RG 31 resumed the touching and masturbation "about

176 RGL 068.
177 RGL 002.

two or three times a fortnight", until HIA 83 was moved to another unit.[178] HIA 83 never reported this abuse as he did not think people would listen to him.[179] We accept the witness's accounts of events, but do not think that his experiences suggest that there was systemic sexual abuse of boys during this phase.

Phase 1 (1958 to 1985): Allegations of Emotional Abuse by Staff

124 Three of the witnesses from this phase made allegations of emotional abuse. Clearly, other forms of abuse have a serious emotional impact, such as the persistent fear of physical punishments or bullying, or the humiliation and guilt often associated with sexual abuse.

125 HIA 200 said that he felt he had an inferiority complex because of the way he had been bullied. He remembered being punched by other boys at night and there was no one to complain to, as no one listened. RG 73 used to encourage other boys to tease him, and HIA 200 was humiliated in class when RG 73 taunted him and implied he was gay, which made all the other boys laugh.[180] His housemaster called him "names like 'sleekit', 'slimy' and 'underhand'" in house meetings; these names stuck and HIA 200 said he was still sensitive about people perceiving him that way.[181]

126 We accept that the use of name-calling by staff is hurtful, can undermine a child's self-confidence and may rankle for many years afterwards, as HIA 200's account demonstrates. It is poor childcare practice. However, in our opinion, HIA 200's experiences are insufficient for a general finding of systemic abuse.

Phase 1 (1958 to 1985): Allegations of Abuse by Peers

127 Witnesses provided examples of bullying, usually of younger, weaker boys by bigger, older boys. Such events were not uncommon in places such as training schools, where some of the children will have experienced violence at home and may have become disturbed and violent themselves. Vigilance on the part of staff and the creation of a positive atmosphere which encourages children to be supportive towards each other can counter bullying. The question, therefore, is whether the staff at Rathgael were alert to bullying and whether they took action to prevent or minimise it.

178 RGL 005.
179 RGL 003.
180 RGL 040.
181 RGL 040.

128 HIA 400 saw himself as:

> "a small, skinny child, who was vulnerable and weak, so I would have been a target for bullies. I experienced lots of unnecessary violence."[182]

He described seeing another boy bullied at night, made to strip naked and dance on a table, having shoes thrown at him, and being made to put his penis on a table, where the bullies hit it with shoes.

129 There was a gang of five or six boys who ruled the twenty-bedded house unit:

> "They did a thing called 'hooding'. ...when you were sitting on a chair one of them came up behind you and pulled their jumper over your head and held it tightly. The rest of the unit would fly over and punch you and kick you while the jumper was still being held over your head. There was not a day that passed when I didn't either receive or see someone else receive a 'hooding', a beating or be spat on. I constantly had split lips and black eyes."[183]

130 One bully, RG 71, treated HIA 400 as a slave, making him run errands, clean his shoes or dry his hair. He found this humiliating and after his Christmas leave he decided not to return. Although it was winter he was on the run for a month, committing crime to survive and living in a lock-up garage and a tree house. When he was apprehended and returned to Rathgael the peer abuse he had suffered eventually stopped, partly because the abusers had been moved to Millisle and partly because he had grown and was establishing himself as a stronger character.[184]

131 He said that staff must have known about the bullying, but they tended to stay in the staff room, and no one dared to 'tout' and tell the staff:

> "...you lived in fear if there was a member of staff on duty who spent a lot of time in the staff room, as you knew that you had no protection from the bullies that shift. There was not a lot of interaction between the staff and boys."[185]

He attributed 95% of the physical violence to bullying by peers and only 5% to abuse by staff.[186]

182 RGL 094.
183 RGL 094.
184 RGL 095.
185 Day 152, p.119.
186 Day 152, p.122.

132 HIA 400's conclusion was that:

> "I think Rathgael was badly managed and therefore there was no protection for the boys from other boys."[187]

HIA 172 says that he became like the thugs who had bullied him, and he gave one bully a black eye. He was not proud of what he had done.[188]

133 Our conclusion is that the evidence substantiates the assertion that there was - at least on occasion - bullying which the staff could have prevented. Where staff actively supervised and engaged with the boys, bullying was prevented, and it took place when staff who were known to do so absented themselves. **We therefore concluded that the failure to prevent bullying by peers amounted to systemic abuse**.

Phase 2 (1985 to 1995): Allegations of Physical Abuse by Staff (Boys)

134 As noted above, the pattern of allegations of abuse changed with the arrival of the girls from Whiteabbey. Only four male applicants alleged physical abuse during the second phase and, with one exception, the allegations concerned incidents which took place early in the phase, they largely related to measures taken by male staff to control boys, and at times they reflected the difficult behaviour which the staff were expected to manage.

135 There were two occasions on which HIA 429 was restrained, both of which escalated from minor problems into serious incidents. In one, involving RG 20, HIA 429 was pinned down and punched, and he attributed his current spinal problems to the way he was hit.[189] RG 20 denied this allegation.[190] In the second, an argument developed into a fight in which HIA 429 was thrown over a sofa by RG 49, the head of his unit, and to defend himself against punches, HIA 429 hit RG 49 with a poker, breaking his little finger.[191] HIA 429 was confined in the D Room, where he broke the window to escape, and he was moved to House 5 in the justice side of Rathgael with a view to his discharge. HIA 429 was convicted of assault for this incident, but the Director of Public Prosecutions directed that RG 49 should not be charged.[192]

187 RGL 094.
188 RGL 021.
189 RGL 109.
190 RGL 4793.
191 RGL 45532.
192 RGL 109-110, 4838.

136 In his first few days at Rathgael, HIA 172 was hit with a back-handed smack in the face by his houseparent, RG 50, when he complained that someone had spat in his cereal.[193] On being moved to the care side, HIA 172 was locked in a room (possibly by RG 4) and he said his arm was twisted so far up his back that his shoulder was almost broken. No one responded when he banged on the door to go to the toilet, and he had to defecate on the floor.

137 A walkman which his mother had given to HIA 172 was stolen - by staff, he believed.[194] When he complained about staff stealing his things, his housefather, RG 49, punched HIA 172 in the stomach. As he was also being bullied, he felt under attack by both peers and staff, and started self-harming. When he rang Childline he was placed in the secure unit, House 4. When he absconded, RG 48 punched him in the head on finding him.[195]

138 HIA 172 said that his behaviour became more bizarre as he wanted to be removed from Rathgael to hospital; he self-harmed and ate non-food items, such as the components of a smoke detector. He was taken to casualty and given laxatives before being returned to Rathgael. The next day he was moved to a psychiatric unit in Downshire Hospital, before being returned once more to Rathgael and placed in Shamrock House.[196]

139 HIA 172 considered all the teachers to be violent. RG 33 punched and kicked him in a broom cupboard and RG 62 punched him in the back of the head. His allegations about RG 17 have been quoted above.[197]

140 HIA 182 was the only male applicant to allege physical abuse in the last decade that Rathgael was open. He was there for only three months in 1989 and he remained in the reception house. He said that residents were punished for "not complying with instructions, self-harming or generally messing around". RG 11 was seen as "the Enforcer" and other staff looked up to him. HIA 182 alleged that RG 11 punched him and kicked him with his trainers while gripping him by the hair or the throat. He witnessed other young people being dragged away by RG 11 and hearing their screams getting louder. He said that other staff were aware of what RG 11 was doing but were scared of him. Another member of staff, whose

193 Day 158, p.12.
194 RGL 016.
195 RGL 017.
196 RGL 018.
197 RGL 020-021.

name HIA 182 could not recall, also beat him up for messing around in the television room. HIA 182 said that it was during this time that he started self-harming.[198]

141 RG 11 said that HIA 182's allegations were "false and entirely without foundation." He considered the allegations to be malicious, as HIA 182 had later worked at the Lakewood Centre and RG 11 had been his superior. He listed six disciplinary issues which had emerged concerning HIA 182's work, including sleeping on a night shift.[199] RG 11 also denied the allegations which HIA 182 had made to the police on 24 January 2013; these allegations were of assault, similar in nature to this in his statement to the Inquiry but including further detail. HIA 182 had also told the police that RG 11 had assaulted him "probably about a dozen times". RG 11 categorically refuted any suggestion that he was violent to HIA 182 or any other resident in his charge.[200]

142 The allegations indicate the disturbed behaviour with which the staff had to cope. In some of the instances it might have been possible to divert the boys rather than confront them and use force to ensure compliance, so that the problems did not become crises leading to even more disturbed behaviour such as self-harming. Unless there are implications concerning systemic failure, it is not generally our role to make findings on individual allegations, but overall it seems that at times excessive force was used to maintain control. However, the issues involved were complex, and we do not consider the scale of the allegations as amounting to systemic abuse, as the number of serious incidents was not large, taking account of the number of boys who were resident at the time.

Phase 2 (1985 to 1995): Allegations of Physical Abuse by Staff (Girls)

143 The allegations of physical abuse made by female witnesses to the Inquiry all related to restraint and action taken by staff to place them in secure accommodation. The evidence largely relates to the mid-1990s, though some of the people who spoke to the police about physical abuse were at Rathgael in the 1980s. It could be argued that initially the staff at Rathgael had had inadequate preparation to work with adolescent girls when they arrived from Whiteabbey, but this argument was no longer valid in relation to the allegations recounted below.

198 RGL 025.
199 RGL 4824-4825.
200 RGL 4826.

144 HIA 438 was most unsettled and in her two years in Rathgael from 1988 to 1990 she absconded thirty times, going straight home to her mother, typically being picked up by the police next day and returned to Rathgael. At first she was placed in a single bedroom on her return, but later she was admitted to Shamrock House, as it was more secure.[201]

145 HIA 438's complaint was that excessive force was used in restraining her and placing her in secure accommodation. On one occasion six members of staff were involved, one of whom she bit. She said that they were "very forceful" and she thought that one of them had broken her arm. HIA 438 said that she had a very slight build and the way in which staff handled her left bruises on her arms and body, as they pinned her arms behind her back.[202]

146 HIA 438 began to self-harm and cut her arms. She saved up to buy paracetamol and tried to take her life on several occasions, but she said she was never asked why she ran away or given counselling or pastoral care to counter her negative feelings.[203]

147 HIA 386 was placed at Rathgael on three occasions, amounting in all to nearly two years. It is clear from her statement that she was going through a very disturbed phase while at Rathgael. She was being cheeky and aggressive to staff, glue-sniffing, refusing to go to sleep at night, "slicing" her arms, cutting her face and body in circles and pulling the skin off her face, causing herself a lot of pain.[204] Rathgael records confirm her account, with incident reports detailing abusive language, damage to furniture and equipment, lashing out at staff and a barricading incident, among other things.[205]

148 The staff restrained HIA 386 and locked her in the "care unit", known as the 'D' room or Shamrock room. She described it as a cell where she felt "totally trapped". The room had only "a thin blue mattress on the floor" and she found the food so disgusting that she became a vegetarian. HIA 386 said that she was constantly monitored, even when she went to the toilet, and she had no time to herself. Nor was she permitted to mix with other children. She felt that the staff were uncaring, "very hard" and "only here for the money".[206]

201 RGL 120-121.
202 RGL 121-122.
203 RGL 123.
204 RGL 082-083.
205 RGL 44472, 44473, 44479.
206 RGL 083, 084.

149 She wrote that she was hit, kicked in the shins, spat on and trailed by her hair, but her main complaint was the mode of restraint used by staff:

> "[RG 11] used to trail me up to the Shamrock room with another member of staff, usually another man, and I would only have been wearing a night dress. One man had me by the feet and the other by the arms. My dignity wasn't protected at all and I used to squeal for them to let me down. All of my private parts were out and there were maybe two or three people on top of me, with my arms forced behind my back and my face squashed into the floor. If I was wearing jogging bottoms at any stage and they came down, then my underwear was on show. They didn't let me get covered up and I was often put in there wearing my nightdress for seventy-two hours."[207] [208]

150 HIA 389 also self-harmed and took overdoses of tablets on several occasions, as she was "constantly bullied by both staff and residents".[209] She made similar complaints about restraint:

> "This involved being thrown to the ground, usually having my arm twisted behind my back and sat on. I was not able to breathe and was left bruised from these ordeals. Often depending on what I was wearing when I was being restrained, staff did not care if my private parts were exposed. I would have been restrained at least once every fortnight."[210]

151 She described the D Room as:

> "empty with the exception of a gymnasium mat on the floor. It was like a prison cell. The room had no windows and the door had a spy-hole. ...When I had to use the bathroom I would have had to press the buzzer to gain a member of staff's attention, although staff often never responded. At meal times staff would throw in food to the room as if they were feeding animals."[211]

152 HIA 231 said that:

> "At times I found the way the male staff at Rathgael physically restrained me to be excessively forceful. The female staff would usually try to reason with me first if I refused to do something. They had a more gentle approach. However, the male staff [RG 48] and [RG 47] would just go straight in and physically restrain me. They were well-built men.

207 RGL 082-084.
208 Also described in detail on Day 155, p.9.
209 RGL 090.
210 RGL 088.
211 RGL 089.

> They would hold me with my head face down in the carpet and twist my hands behind my back in order to restrain me. I had a very slight build at that time. They could have held me down with one hand. I felt that the way they treated me amounted to physical abuse."[212]

153 HIA 503 spent two periods in Rathgael, first a fifteen-week assessment and secondly following her committal under a Training School Order. She complained about physical abuse, and in particular about undue restraint during both her times at Rathgael.[213] At a case conference it was recorded that HIA 503 was physically and verbally aggressive towards staff and was non-compliant to the simplest requests.[214] She hit out, kicked and spat at staff, but having ventilated she calmed down quickly.[215] A specialist therapeutic placement was recommended, but no places were available.[216]

154 During her first spell at Rathgael, she was restrained by RG 3, who was ex-military:

> "He put my arm right up my back and pressed on a pressure point on my thumb which paralysed me with pain."[217]

On another occasion, when she wanted to stay longer in the swimming pool, RG 4:

> "...took me out of the pool using a large hook and sat on me. I would estimate him to be 18 stone weight. My face was pushed against the tiles..."[218]

155 She wrote that during her second period at Rathgael:

> "I also had to be taken to hospital due to being restrained by staff. On one occasion my wrists were very painful. At hospital I had to have splints applied to my wrists. I was usually taken to Newtownards Hospital when I sustained injuries as a consequence of being physically restrained. Hospital staff asked how I sustained the injuries. I told them while being restrained, but they never asked who in particular caused the injuries."

212 RGL 047-048.
213 RGL 129-133.
214 RGL 884.
215 RGL 885.
216 RGL 886.
217 RGL 130.
218 RGL 130.

156 "On another occasion while being restrained I twisted the muscles in my back and found it difficult to walk for several weeks. The Matron rubbed my back with a cream to relieve the pain. If I had been restrained during the night I would be in my night clothes. Staff would drag me, each holding a leg and an arm, my underpants would be visible and my breasts would be on display."[219]

157 HIA 503 said that she still suffered:

"pain in my knees as a consequence of being continuously [sic] restrained and slammed against the ground whilst in care."[220]

158 HIA 389 alleged that RG 5 "constantly physically and mentally abused" her, and on one occasion, when she wanted to spend a longer time swimming, she:

"...dragged me out of the pool using a long-handled net before she grabbed me and twisted my arm up my back. I screamed in pain. Other residents tried to release her grip on me. I had to be taken to hospital following this incident as my arm was left badly bruised."[221]

159 HIA 268 alleged that she was injured by RG 33. Her version of events was that she had been glue-sniffing with two other girls, and when he took her to his office she attempted to climb out of the window. When part-way out of the window she was knocked against a wall by RG 33, pinned by her throat, knocked unconscious and injured. When she regained consciousness, blood was running from her head, and RG 33 knocked her against the wall again. She required six stitches at Newtownards Hospital.[222]

160 His version was that the incident took place in RG 34's office. Her behaviour was "erratic and unpredictable" and her language was "loud and obscene"; he thought she was under the influence of some intoxicant. She climbed onto RG 34's desk, which was positioned under a window, and tried to climb out. RG 33 estimated that there was a drop of eight to nine feet to the ground from the window. As he attempted to guide HIA 268 away from the window and off the desk she lost her footing and hit her head on a bookcase.[223]

219 RGL 133.
220 RGL 133.
221 RGL 090.
222 RGL 074.
223 RGL 4796-RGL4797.

161 RG 33 clearly had to take action to prevent HIA 268 from climbing out of the window, and if she were affected by sniffing glue, her fall was unsurprising and her recollection of the incident may have been affected. We believe that RG 33 acted appropriately.

162 These accounts highlight the dilemma which is posed by restraint. It is obviously preferable if behavioural problems can be avoided in the first place, and in the best childcare practice children can often be diverted or talked out of seriously damaging behaviour. However, when a disturbed child is acting hysterically or is at risk of harming self or others, or is causing damage, restraint may be unavoidable.[224] If so, the type of indignities which HIA 386 and HIA 389 described can be difficult to avoid.[225] Furthermore, it is often to the stronger staff that their colleagues turn when restraint is required, and, as the evidence shows, the problems are accentuated if male staff have to be involved in restraining adolescent girls. The distress experienced by the girls is understandable, but it is often hard to know what else the staff could have done in the circumstances. What is more, while the use of separation rooms provided staff with temporary control over the situation, it did not provide a long-term solution, and constraining young people in this way could also have been damaging if they resorted to more extreme behaviours such as self-harm and even attempted suicide in consequence.

163 Dealing with such situations is one of the most demanding and difficult tasks in residential childcare. It is our impression from the evidence that: restraint was probably used too readily, rather than as a last resort; that it was applied more often than was required; that excessive force was used, taking account of the disparity in size of the male staff and the girls; and that the regular reliance on male staff to control the girls presented risks to both the girls and the staff.

164 The lesson to be learnt is possibly that some residents were inappropriately placed in Rathgael, even if it was the best that was available in the province. In the case of HIA 503 it was noted that no therapeutic placement was available for her. Young children requiring therapeutic placements were on occasion placed in Lissue, and young people, such as HIA 172 who spent eighteen months at Peper Harow, were at times placed in units in England, but there was no such unit in Northern Ireland. The behaviour problems which some young people presented may have been beyond the skills

224 RGL 44480.
225 RGL 084, 088.

of the staff at Rathgael. If so, rather than blame them for the systemic failure of restraining the girls in inappropriate ways, it is probably the planners who failed to make suitable provision available who should bear the responsibility. Whoever should be held accountable, we acknowledge that the witnesses found their experiences of restraint unpleasant, painful and at times degrading and humiliating.

165 RG 47 told the police that when Rathgael and Whiteabbey were merged in 1985, "...we were ill trained and totally ill prepared and grossly understaffed." They had to take on staff with no experience.[226] It is not until March 1990 that there are records of staff being trained in control and restraint,[227] and the training materials supplied were prepared for the Northern Ireland Prison Service and are dated 1 January 1991.[228]

166 It was noted in police enquiries in 1986 into improper conduct on the part of a residential social worker RG 91, shortly after the merger in 1985, that there had been no training for staff at that time. He had worked with boys in Rathgael for eight years, and had had to learn how to handle situations with girls from colleagues at staff meetings. The lack of training was seen by Detective Chief Inspector Thompson as:

> "a serious error of judgement on the part of the Rathgael and Whiteabbey Schools Management Board and a contributory factor in this incident occurring."[229]

This criticism would presumably have applied not only to training in control and restraint, but also to any problems for male and female staff from either school in relating to children of the opposite sex.

167 If, therefore, the staff of Rathgael were having to cope with behaviour for which they had not been trained, staff would presumably have had to develop their own methods of coping. We do not therefore, place responsibility for the excessive restraint described above on the individual staff members involved, but on the Department which placed them in this unhappy predicament. **We consider the lack of training in control and restraint to have been a systemic failing**.

226 RGL 34146.
227 RGL 100544.
228 RGL 100001.
229 RGL 38275.

Phase 2 (1985 to 1995): Allegations of Sexual Abuse by Staff (Boys)

168 One person who spoke to the police made allegations that he had been sexually abused, but none of the witnesses to the Inquiry did so.

Phase 2 (1985 to 1995): Allegations of Sexual Abuse by Staff (Girls)

169 All the allegations considered up to this point reflected problems arising from the normal running of a training school for children and young people presenting a variety of problem behaviours. Staff may at times have used inappropriate methods of control or been excessive in their application, but they were part of the ordinary way of managing daily life. By contrast, sexual abuse should never have occurred, and it would have been known to all concerned that it was unacceptable. The allegations made by girls that they were sexually abused at Rathgael are the most serious which we had to address during this module. In all, six applicants and thirteen others made allegations of sexual abuse during this phase.

170 HIA 268 was one of the ten girls who were transferred to Rathgael when Whiteabbey closed. Soon after her arrival a maths teacher, RG 27, started to take a personal interest in her. He organised fishing trips, so that while the other residents went fishing, RG 27 and HIA 268 could stay in the van together and kiss. There was "no sex, just kissing and friendship", and the one occasion when they attempted intercourse failed as he could not achieve an erection. RG 27 also bought her cigarettes and took her to bars where he bought her alcoholic drinks.[230]

171 The relationship continued for two years and HIA 268 said she believed that staff were aware, although she was never questioned. She thought that someone reported RG 27.[231] RG 27's personnel records have been destroyed, but two documents have survived. A hand-written note indicates that he was to face a number of questions about being in licensed premises, borrowing cars and taking HIA 268 off the premises without permission.[232] The second is a minute of a meeting of the Disciplinary Committee of the Management Board, at which it was decided that RG 27 should be given a final warning for taking HIA 268 to licensed premises.[233] HIA 268 thought that RG 27 was dismissed or made redundant.[234]

230 RGL 073.
231 RGL 073-074.
232 RGL 28515.
233 RGL 22971.
234 RGL 074.

172 In August 1985 (five months after the first girls had been transferred from Whiteabbey to Rathgael) a disciplinary inquiry was held into allegations of improper conduct against a residential social worker RG 91, who had kissed, and written "romantic" letters to, a girl RG 157 for whom he was keyworker. He had become emotionally over-involved, but there was no allegation of sexual abuse, and he was given a warning and moved to a boys' unit. The police later investigated, but no action was taken, partly because of the lack of training to prepare existing male Rathgael staff to work with girls.[235]

173 HIA 198 alleged that RG 20 grabbed her with both his hands around the chest area and pulled her into the house, after she had been mouthy and refused to enter the building.[236] RG 20 denied this allegation.[237] There are also allegations which are less serious. HIA 198, for example, used to dread times when RG 2 was on duty because he would flirt with all the teenage girls. [238]

174 HIA 389 alleged that RG 20 "would often pretend to tickle me. In reality he was fondling my breasts"; she added that he also did this often to RG 23.[239] This was "emphatically" denied by RG 20.[240] [241]

175 HIA 231 provided detailed allegations concerning sexual abuse by RG 48, who was then "a well-built man in his mid-forties". She said that he was:

> "well respected by other staff and they deferred to him a lot on day to day matters regarding our welfare. There was a perception that he was beyond reproach."[242]

176 As a typical example of her allegations, HIA 231 wrote that RG 48:

> "...began sexually and physically abusing me almost as soon as I moved to House 6. He did not hit me but he was always very forceful when he grabbed me and pinned me down or against a wall. One evening I was doing the dishes in the kitchen of House 6 and he came up behind me. He puts his hands down the front of my trousers and forced his fingers inside me. I could feel him rubbing himself against

235 RGL 38263-38293.
236 RGL 033.
237 RGL 4793.
238 Day 155, p.52.
239 RGL 091.
240 RGL 4793.
241 Day 155, p.37.
242 RGL 045.

me from behind and I could feel his erection through his clothing. I told him to pull his hand out and get him to stop but he wouldn't. This happened every time he and I were alone. He took his chance to touch me at any opportunity."[243]

177 She said that on other occasions she was assaulted in the TV room, when ill in bed in House 6, and when he was dressing her wounds after HIA 231 had cut herself, a practice which she started "as a way of coping with the sexual abuse I was experiencing at Rathgael".[244] RG 48 also gave her extra treats, such as cigarettes, and presents, including trainers and a Thornton's Easter egg with her name on it. Looking back she considered this behaviour as being manipulative, as a way of buying her silence.[245]

178 HIA 231 believed that HIA 236 was also abused by RG 48. In 1995 RG 88 complained about sexual abuse by RG 48, but when HIA 231 was questioned by police she:

"protected [RG 48] at that time because I genuinely liked him and he was good to me."

In her statement to the Inquiry, HIA 231 said that she now cringed at her failure to support RG 88.[246]

179 HIA 236 also alleged that RG 48 sexually abused her at every opportunity until she left Rathgael, kissing her, putting his hands under her clothing and digitally penetrating her.[247] There is no suggestion in her brief account of the abuse by RG 48 of any of the reciprocal feelings which she and RG 47 had for each other (described below). RG 48 denied the abuse, and said that he:

"never at any stage touched [HIA 236] in a manner which could be construed as sexual."[248]

180 A member of night staff, RG 82, let HIA 438 sit in the office with him and have a smoke. She alleged that twice he touched her breast through her night dress. She threatened to report it, but he pointed out that no one would believe her. She told a member of staff RG 52, who said she would talk to HIA 438 about it later, but then went home.[249] HIA 438 told her boyfriend, and assumed that he must have said something, as it stopped

243 RGL 045-046.
244 RGL 046.
245 RGL 047.
246 RGL 050.
247 RGL 057.
248 RGL 4817.
249 Day 153, p.54.

after that.[250] RG 82 provided a detailed rebuttal of this allegation, among other things pointing out that girls were checked at night by female night staff.[251]

181 The sexual abuse alleged by HIA 236 is unique in this Module in that it led to an ongoing relationship in adult life. It should be noted that, although RG 47 has acknowledged that he had a relationship with HIA 236 as an adult, he has consistently denied having sexual relations with her until she attained adulthood.[252]

182 HIA 236 said that when she went to Rathgael RG 47 was a senior member of staff, aged 46:

> "If there was any trouble he was the one who came and sorted it out. [RG 47] paid me more attention than the other girls. He came down to the kitchen in House 4 and cooked with me once. He was always playing pool with me and he knew I liked him. I was confused sometimes because of the way he behaved with me. Things started to get tense between us. I wished he would leave me alone at times and yet at other times I wanted him to talk to me. I talked to [RG 47] about the sexual abuse I suffered at the hands of family members. I felt I could talk to him as he seemed interested in what had happened to me and asked me questions. I think this is why I saw him as a father figure."[253]

183 "One day I was misbehaving... [RG 47] put me in the lock up room for an hour and a half. He then handed me some paperwork which said that I was going to be sent to Maghaberry for the rest of my training school order. I was extremely upset and started to cry. He held open his arms and I hugged him. He asked me if I hated him and I replied that I probably liked him too much. He told me he felt exactly the same and that I couldn't tell anyone. He kissed me on the cheek. When I asked about Maghaberry he ripped up the paperwork. ...He walked me back to the school block and told me he loved me. I said that I loved him too but I think I was shocked and confused. I loved him as a father figure. This happened on 31st May 1994. I know the date because [RG 47] would write it in cards and letters he sent to me and in later years in text messages."

250 RGL 122.
251 RGL 4789.
252 RGL 4866.
253 RGL 055.

184 In her statement HIA 236 went on to describe how the relationship developed from kissing and telephone calls to sexual touching over clothes and then intercourse on a regular basis. The relationship continued for fourteen and a half years, and HIA 236 was hoping to conceive RG 47's baby. The relationship broke down when HIA 236 found that RG 47 had been having a long-term relationship with another woman, and that he had had a vasectomy many years earlier. HIA 236's retrospective view was that RG 47 had groomed her from the age of fourteen.[254]

185 RG 47 said that on 31 May 1994 he spoke to HIA 236 at length and threatened her with a permanent transfer to Maghaberry, because he was happily married with two kids and he was becoming exasperated with her obsessional behaviour.[255] He also continued to pick her up, take her home and take her to hospital, despite the obsessional behaviour. He was questioned closely by the police about his reason for doing so, and staff shortage was the only reason he could give, as he was the senior member of staff on duty.

186 As noted above, in his written and oral evidence RG 47 firmly denied that any sexual relationship took place until January 1977, when HIA 236 was an adult and he was weak and vulnerable because his mother had died, his father was in hospital with Alzheimer's and his marriage was breaking up.[256] He said that HIA 236 contacted him, and they went to his cottage in Ballyeasborough and had sexual intercourse.[257] RG 47 had no explanation for commencing this intimate relationship when questioned by the police,[258] especially since he had described HIA 236 as "exceptionally volatile", displaying "outrageous behaviour", and reacting "violently and unpredictably" when at Rathgael.[259]

187 HIA 236's account is consistent with evidence from a number of sources. A note in HIA 236's occurrence sheet records that when she was non-compliant in the schoolroom she was returned to the house by RG 47. The writer of the occurrence sheet noted:

> "I am not happy with the management of [HIA 236]'s non-compliance. Already she is being perceived by her peers as special. I have spoken to [LN 7] and he is aware of my concerns."[260]

254 RGL 056-057.
255 RGL 34226.
256 RGL 4866, 34155.
257 RGL 34156.
258 RGL 34156.
259 RGL 4865-4866.
260 RGL 42050.

188 In a statement to the police LN 115 said she was HIA 236's key worker and she was aware of HIA 236's crush on RG 47, and the impact that his presence had on her. HIA 236 was happier when RG 47 visited her house unit, and was tearful when he left. LN 115 recalled one time when HIA 236 wanted to disclose something but appeared fearful of doing so, and said nothing. LN 115 was very concerned and spoke to RG 57 about it, who said that RG 139 had also approached him, but the matter appears to have gone no further.[261] RG 82 was a night supervisor and he was shocked on checking into the office one night to find RG 47 hiding under a table in the dark from a girl who was looking for him, and he was waiting for RG 250, another night supervisor, to take him to his car, which was parked some distance away, to avoid detection by the girl.[262] RG 82 met the girl later on his rounds and told her that RG 47 had gone off centre, so she returned to her unit. It was explained to him next day that RG 47 was being stalked by the girl, though he never learnt her name.[263]

189 HIA 231 told police in 2013 that while at Rathgael HIA 236 had told her that she was having a relationship with RG 47, and that she "couldn't get her head round it" as she was so shocked, because RG 47 was a senior member of staff:

> "I then started and noticed the way they were looking at each other, the eye contact, the staring and the flirting."[264]

She also quoted the name 'Boo', which HIA 236 said that she and RG 47 used for each other, and said that she had been with them on a trip to the seaside, during which she had been left to occupy herself for an hour and a half, and had witnessed them kissing.[265]

190 In 2013 RG 276 provided a police statement that she had been told by RG 45 that her cousin, HIA 236, was having a relationship with RG 47, who was Assistant Head of Youth Treatment of Rathgael at this time. She reported this to RG 73, the team leader of the neighbouring house unit, (as her own team leader was on leave) but he subsequently denied having the conversation, possibly covering for RG 47, in her opinion.[266]

261 RGL 34215-34216.
262 RGL 34218-34219.
263 RGL 4791.
264 RGL 34202.
265 RGL 34203 and RGL 34206.
266 RGL 34219.

191 HIA 236's description of events showed that their relationship was conducted secretively, but it is nonetheless surprising that it does not seem to have been properly questioned by colleagues or recorded in HIA 236's file. RG 47 was well respected and was promoted three times within Rathgael to the post of Assistant Director on the justice side because of his ability.[267] Lindsay Conway, the Director of Rathgael, described RG 47 as "a very capable and caring manager with a flair for organisational matters", who related very well to young people, parents and staff, was an able communicator, worked well in a crisis, and was open to change.[268]

192 We accept HIA 236's version of events, however, it is clear that, whichever account is correct, RG 47 and other staff mishandled events. There are times when the forming of a close relationship with a member of staff can be of real help to a child or young person, but to ensure that the child's needs are met, the matter needs to be discussed fully with colleagues and recorded, not only to monitor the way things develop and avoid the abuse of the child but also to protect the professional.

193 RG 47 described HIA 236 as having "an obsessive crush" on him.[269] It is hard to believe that such a close relationship was not observable, and the evidence is that some of RG 47's colleagues did have concerns, though they did not follow them through to ensure that the matter was properly investigated. Handling the crush was a matter he should have shared with colleagues in accordance with her care plan, and yet he persisted in placing himself in compromising situations where he was alone with HIA 236.

194 **We accept HIA 236's account of her relationship with RG 47. His sexual exploitation of her, his failure to raise concerns about HIA 236's crush with colleagues and their failure to question the relationship properly all constituted systemic abuse**.

195 As noted at the beginning of this section, a total of nineteen people have complained either to the police or this Inquiry about sexual abuse, and the instances recounted above are only examples. This would suggest that particularly in the later years - in the early 1990s - some staff had come to think that they could sexually abuse girls with impunity. Such thinking is not likely to have been in any way made explicit and most staff may have

267 RGL 34135.
268 RGL 34277.
269 RGL 4866.

been quite unaware of their colleagues' conduct. If some staff were aware of inappropriate relationships, such as RG 47's with HIA 236, as some of the evidence suggests, action should have been taken to identify possible abuse and address it. If staff were unaware, it suggests that relationships between staff and residents were such that none of the nineteen girls felt able to disclose the abuse they have since alleged. It should be noted that two of the staff against whom serious allegations have been made were in senior positions, and they will have had an influence on the general atmosphere and attitudes in the school community as a whole.

196 **We are satisfied that a small number of staff sexually abused girls during this phase and that this amounted to systemic abuse**.

Phase 2 (1985 to 1995): Allegations of Emotional Abuse by Staff

197 There is only one instance where an allegation was primarily concerned with emotional abuse. HIA 172 said that he and another boy were humiliated unnecessarily in front of all the other children, being accused of masturbating over the toilet, when the substance was actually shampoo.[270]

198 However, the allegations of physical and sexual abuse described above all carried connotations of serious emotional abuse. The girls, for example, bitterly resented being restrained and felt humiliated.

Phase 2 (1985 to 1995): Allegations of Abuse by Peers

199 In relation to bullying, Lindsay Conway stated that staff started to question certain behaviours from the early 1980s and that there was:

> "growing recognition that bullying was not acceptable and could not be tolerated when detected."

Where necessary, action was taken to transfer children to other units, or to apply sanctions such as the loss of points or pocket money.[271]

200 There were references to bullying during the second phase, but they were few and general, rather than specific. HIA 172, for example, said he was "badly beaten" by other residents.[272] When HIA 503 approached other staff to report the bullying she was told to grow up and "sort herself out", or that the bullying was all in her head.[273] This may have occurred after the dates covered by the Inquiry's Terms of Reference.[274]

270 RGL 019.
271 RGL 5109.
272 RGL 016.
273 RGL 131-132.
274 RGL 46959.

201 About 1992 an Independent Representative Scheme was introduced in relation to Shamrock House under the auspices of the Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO), providing a further assurance mechanism through external scrutiny. This was in accordance with good practice in the care of children in secure units at that time.[275]

Conclusion

202 In summary, Rathgael was expected to provide care and education for young people with a variety of problems, including offending, and for some of its history it was the only residential school of this type to serve the Protestant community. The school appears to have been well financed, with carefully designed purpose-built buildings, excellent resources to provide the education, care and leisure activities required by their residents, a busy programme for the children and young people, a sufficient staffing complement in both numbers and variety of staff, good access to professional support for the staff from the APRU, and senior staff and managers who encouraged continuous improvement in working methods.

203 We acknowledge that there were some complaints concerning daily living at Rathgael, for example about food, but overall the school's professional practice appears to have been fundamentally sound, as evidenced for example in its comprehensive system of assessment of the children, the provision of an intensive care unit for children at critical times, the considered response to the problem of absconding and the excellent aftercare service. The allegations of abuse described have to be seen against this background.

204 The abuse took two main forms. In the earlier phase, when there were only boys at Rathgael, the complaints were primarily about harsh treatment and physical abuse. These complaints continued into the early years of the second phase, when the girls from Whiteabbey had been admitted. The other main form of abuse occurred in the second phase, particularly in the later years, and concerned the sexual abuse of girls.

205 Understandably the people who have come forward as witnesses had unhappy experiences of Rathgael. HIA 231 said:

> "My behaviour was in Rathgael wayward and difficult for the staff to

275 RGL 5101.

control at times. However, there was very little engagement by the staff with the underlying problems which triggered my bad behaviour."[276]

HIA 198 wrote:

"I did not receive any life skills during my time spent in Rathgael, for example, how to look after my appearance or respect myself. I was not prepared for life when I left care."[277]

HIA 172 said in conclusion:

"I have been permanently scarred by my experience at Rathgael. The children were brutal and violent and the staff turned a blind eye. I lived in fear of everyone around me and was beaten by both children and staff…There seemed to be a culture of assaulting children as a means of management and getting children hooked on cigarettes as a means of asserting control."[278]

HIA 200 said that looking back he could see that, although getting into trouble, he was quite innocent on arriving at Rathgael, but that he was exposed to a lot of negative influences and his own behaviour escalated until he was involved in serious drinking and crime. Yet he felt very insecure and was never taught to value himself and never had the confidence to develop his career. He missed so much education that he ended up as a labourer like his father.[279]

206 As with the other homes we have examined, there were residents who saw their experiences more positively. HIA 182 concluded:

"Despite the issues I have with Rathgael, I enjoyed my time there in comparison to the political situation I was living in in Belfast. Undoubtedly it was a place of safety and the majority of staff could not have done enough for you and were kind people. I believe that the problems with the care in Rathgael were the result of deficiencies in the recruitment, supervision and training of staff."[280]

207 In trying to understand how a well resourced training school with high standards could be viewed so critically by some of its former residents, we identify three main factors.

276 RGL 048.
277 RGL 034.
278 RGL 022.
279 RGL 041-042.
280 RGL 025.

208 Firstly, Rathgael had a long history as a reformatory and training school and there were some staff who maintained traditional ways of keeping order, and these entailed physical abuse.

209 Secondly, the boys and girls admitted to Rathgael had some of the most troubled histories of children in the province, and they brought with them considerable problem behaviour, including offending. Despite important attempts to update its approach to young people with serious needs, Rathgael was not equipped to provide therapeutic care. It is our view that what was required of Rathgael was in some cases beyond its resources.

210 When being interviewed by the police, RG 47 said:

> "...all of a sudden Northern Ireland Office dropped us all in it and dropped the girls in, and it was sheer...None of us were trained for it. We didn't know what the hell to expect and things just went belly up from then on; you were chasing your tail 24/7."[281]

RG 47's comments may have been unguarded, but they probably reflected the truth of the situation at times.

211 Thirdly, in the later years in particular, the experiences of some of the girls were made worse by sexual abuse. Although the evidence we heard was persuasive, it was not disclosed at the time and the abuse was therefore not addressed. The atmosphere cannot have been conducive to disclosure and the concerns which were identified were not properly investigated.

212 The number of witnesses was significant. However, they have to be set against a total of up to 7,000 children and young people who were admitted to Rathgael in the course of its history, and we believe that many children may have benefited from the services offered by Rathgael and we would want to recognise the contribution of the many staff who did a good job.

Summary of Findings

213 **We consider RG 17's practice of using frequent unrecorded informal corporal punishment unacceptable, amounting to systemic abuse.**

214 **We consider NIO's failure to ensure that Rathgael was inspected from 1973 to 1987 to have been systemic.**

281 RGL 34220-34222

215 **We consider that the extent of the unregulated physical punishment applied by some staff amounted to systemic abuse.**

216 **We conclude that the failure to prevent bullying by peers amounted to systemic abuse.**

217 **We consider the lack of training in control and restraint to have been a systemic failing.**

218 **We accept HIA 236's account of her relationship with RG 47. His sexual exploitation of her, his failure to raise concerns about HIA 236's crush with colleagues and their failure to question the relationship properly all constituted systemic abuse.**

219 **We are satisfied that a small number of staff sexually abused girls during this phase and that this amounted to systemic abuse.**

Chapter 15:

Module 7 – Lisnevin

Introduction

1 We considered evidence about Lisnevin Training School (Lisnevin) during Module 7, which dealt with juvenile justice institutions. Module 7 commenced on 01 Septermber 2015 and concluded on 24 November 2015.

2 Twelve applicants referred in their written statements to time they spent in Lisnevin. Two of these applicants, HIA 320 and HIA 50, referred to spending periods in Lisnevin but made no further comment about their time in the school.

3 The evidence of HIA 418 and the responses to it were summarised as HIA 418 could not attend in person for medical reasons. We set aside the evidence of HIA 275 and did not take it into account as he did not appear to give evidence in person and gave no reason for not doing so. We heard evidence in person from the remaining eight applicants.

4 Dr Bill Lockhart OBE, a chartered forensic psychologist provided psychological services in Lisnevin from 1973 until 1983 as part of the Adolescent Psychology Research Unit (APRU). Dr Lockhart provided a detailed statement with exhibits about Lisnevin[1] and gave evidence in person. We also received a statement [2]and evidence in person from LN 25 who worked as a care worker and then manager in Lisnevin. LN 8, a former teacher in Lisnevin, provided a written statement.[3] We are grateful for the evidence from these former members of staff, which assisted our understanding of the operation of the school.

5 We considered response statements to the evidence of applicants and contemporaneous documentation to support these statements provided by the Department of Justice (DoJ) and the Health and Social Care Board (HSCB). We were assisted by a joint statement submitted by the DoJ and the Department of Health, Social Services and Public Safety (DHSSPS), which provided background information about the establishment and operation of Lisnevin.[4] The DoJ also provided a helpful and detailed closing submission responding to the evidence given about Lisnevin during Module 7.[5] We were also assisted by a written statement and

1 LSN 1227-1250.
2 LSN 1224-1226.
3 LSN 872- 874.
4 LSN 925 -957.
5 RGL 90160–90187.

exhibits from Alan Shannon CB,[6] a retired civil servant who held senior policy and operation responsibility for training schools from 1990 to 1992 and a statement from his successor Mary Madden CBE, who held that responsibility from 1992 to 1995[7] and who gave evidence in person during our consideration of St Patrick's Training School.

6 Dennis O'Brien was appointed deputy headmaster at Lisnevin when it first opened. Later in his career he was appointed as an inspector with the Social Services Inspectorate (SSI) and in that role he was a member of the team who undertook the first SSI inspection of Lisnevin in 1988. Mr O'Brien provided a statement which we also took into account.[8]

Establishment of Lisnevin

7 At the time Lisnevin was established the Training School Division in the Northern Ireland Office (NIO) maintained a general oversight of training schools with a focus on budgetary control, the application of the Training School Rules (Northern Ireland) 1952 and related policy and guidance and the promotion of good governance. A related division within the NIO was responsible for criminal justice legislation, including the law concerning juveniles.

8 The DoJ, as the successor body for this aspect of the NIO's work, explained that the NIO established Lisnevin to provide two key services which it considered were necessary to enable the Northern Ireland juvenile justice services to fully function. These were a Special Unit to house boys who would not settle within existing open/non-secure training schools and an Assessment Unit to assist the courts to determine the suitability of boys for residential training.[9]

9 Lisnevin was opened in October 1973 at premises formerly called Kiltonga House, on the outskirts of Newtownards, County Down. It was designed as a non-denominational training school that would provide secure residential facilities for 40 boys aged between ten and seventeen years of age.

10 Before the school opened, it was the subject of a public inquiry because local residents had voiced strong objections to a training school being located in their neighbourhood. The inquiry decided that the school

6 LSN 254-675.
7 LSN 676-760.
8 LSN 875-877.
9 RGL 90160.

should open in Newtownards on a temporary basis, pending the building of a purpose built unit at Rathgael in Bangor, some five miles away.

11 When the school opened in Newtownards both the Special Unit and the Assessment Unit provided places for twenty boys. The main accommodation was in a refurbished nineteenth century mansion called Kiltonga House. Kiltonga House provided accommodation on three floors. The ground floor was used to provide a sitting room for the Special Unit and one for the Assessment Unit, showering and toilet facilities, a small domestic kitchen and an office. At the rear of the ground floor, small bedrooms with only a mattress for furniture were used as isolation/separation rooms. The dormitories for the Special Unit were on the first floor and the dormitories for the Assessment Unit were on the third floor.

12 In addition to the main house there were two wings consisting of temporary sectional buildings: one was used for classroom and office space and the other was used for kitchen and dining space. There were extensive grounds, which included a tennis court, football pitch, a small wooden gymnasium and a large heated greenhouse where the boys were taught horticulture.[10]

13 An eight-foot-high alarmed wire fence was erected around the property. A sectional building just inside the gates of the property was used to house the director's office and administrative and finance staff. A security guard controlled entrances and exits through a locked gate.

Special Unit

14 The Special Unit was designed to deal with boys who had been admitted through the courts to one of the open training schools for reasons such as non-attendance at school, being in need of care, protection and control, or juvenile offending, but whose behaviour in those schools was such that a secure environment was considered necessary. Dr Lockhart told us that many of these boys had extensive records of absconding from their existing open training schools and some had demonstrated violent or very disturbed behaviour in those schools.[11]

15 The decision to transfer boys from open training schools to Lisnevin was an administrative arrangement agreed by the respective managements of

10 LSN 1229-30.
11 LSN 1228.

the schools and was not a court decision. Some of the boys had no record of criminal offending before being transferred to Lisnevin.[12] An Admissions Panel, which considered applications for boys to be placed in the Special Unit, included a member of the NIO's Training School Branch who was there to represent the Secretary of State.[13]

16 The Special Unit was a medium to long-term facility with boys living in the unit for between nine months and three years, with a median of around fifteen months.[14] The boys received education on site and Dr Lockhart explained that classes were rarely larger than three or four boys and a full range of subjects were available, including woodwork, metalwork, art, and PE. He recalled that a highly individualised curriculum based on the needs of each boy was provided.[15]

17 Dr Lockhart also described a weekly points system, and subsequently a token system, which were used in the Special Unit to encourage good behaviour. The achievement of points and tokens provided access to increasing levels of reward and privilege such as trips out and weekend leave. Poor behaviour resulted in demotion and loss of privilege. Dr Lockhart explained that the points and tokens systems were the main means of behaviour management, but when a boy engaged in more serious misbehaviour such as absconding, removal from the group to a separation room was used as a sanction.

18 Corporal punishment was permitted within the Training School Rules. Dr Lockhart explained that on occasion behaviour such as fighting and physical violence would be punished by caning. He explained that caning was normally administered by a bamboo cane to the hand by the head of the Unit or his deputy, that it would be recorded in the punishment book and that no other form of physical punishment was permitted.[16]

Assessment Unit

19 The Assessment Unit catered for boys who had been remanded by the juvenile courts for assessment after a finding of guilt or a case proven. While a significant number of the boys remanded for assessment were charged with scheduled or terrorist offences relating to the Troubles, such

12 LSN 1231.
13 LSN 13731.
14 LSN 1228.
15 LSN 1230.
16 LSN 1234.

as paramilitary activity and riotous behaviour, around 50% were charged with other juvenile crime, such as theft, burglary and criminal damage. A small number of boys were remanded because they were not attending school or were considered to be out of control in a children's home and therefore in need of care, protection and control.[17]

20 The assessment process involved the development of a social profile of the boy and his family, an educational assessment and a psychological assessment. These assessments were then collated and discussed at a multi-disciplinary case conference. In the case of boys remanded by a juvenile court a recommendation for disposal would be agreed and provided to the court.[18]

21 Dr Lockhart explained that the throughput of the Assessment Unit was quite steady and that it mainly ran at full capacity. He estimated that it had a throughput of more than 100 boys per year.[19] However, after only a few years of operation, it was identified that the Assessment Unit was recommending that around 80% of the boys assessed should receive a community disposal on return to court. Dr Lockhart told us this was in stark contrast to the reception units at both Rathgael and St Patrick's training schools which, after conducting their assessments, recommended that around 80% of boys should receive a Training School Order. He explained that this finding ultimately led the NIO to close the Assessment Unit at Lisnevin in 1977 and transfer its work to a day assessment unit at Whitefield House in Black's Road in Belfast. The Assessment Unit staff at Lisnevin moved to Whitefield, which meant that Lisnevin operated solely as a Special Unit for a period of approximately two years.[20]

22 The transfer of the Assessment Unit and the establishment of a junior remand wing in Crumlin Road Prison (mainly for those charged with scheduled offences) meant that young terrorist offenders would no longer be accommodated in Lisnevin. This change in function led to another attempt to have the school located permanently in Newtownards.

23 A second public inquiry about this matter was held in November 1978. Local residents maintained their objections and the inquiry recommended that as the role of the school had not changed substantially and it still had its share of "dangerous and thoroughly aggressive boys" it should be discontinued at its present site.[21]

17 LSN 1230-2301.
18 LSN 1232.
19 LSN 1228.
20 LSN 1232.
21 LSN 1235.

Move to Millisle

24 As a result of the outcome of the second public inquiry, the school moved in 1981 to Millisle, County Down, into premises which had been designed for and formerly used as a secure borstal.[22]

25 The accommodation at Millisle consisted of a main two-storey building enclosed by a perimeter fence. Access to the building was secured by an entrance hall, which was staffed between the hours of 7.00am and 10.00pm, and access from the entrance hall to other parts of the building was secured through the use of electronically controlled doors. Each storey of the building provided two wings of sleeping accommodation, living rooms, classrooms and office space. Workshops for training in crafts such as joinery, metal work and brickwork and a full-size football pitch were located in the extensive grounds.[23]

26 Dr Lockhart told us that the move to Millisle marked a major change in the culture and management of Lisnevin and that in his view the planning and implementation of the move from Newtownards to Millisle was "a disaster".[24] He explained that because the building had been designed as a category C prison it was totally unsuitable for housing children and the lack of planning for the move meant that necessary furniture was not available when the children arrived at the premises.[25]

27 He highlighted two particular aspects of the move which he considered adversely affected the experience of the boys. Firstly, the teachers decided to use the move as an opportunity to redesign the curriculum and this took from September 1981 to May 1982. He explained that while schooling was not available, a culture emerged of the boys sitting watching television during the day.[26] **We consider the lack of schooling for almost a full school year to be a systemic failing by the Lisnevin Management Board and the NIO, as the Department with overall responsibility for the school to ensure that the institution provided proper care.**

28 Secondly, although the site in Millisle was only ten miles approximately from the site in Newtownards it was much more isolated and difficult to reach by public transport. There were few direct buses from Belfast to

22 LSN 930.
23 SPT 16268.
24 LSN 1238.
25 LSN 1238.
26 LSN 1238.

Millisle and even fewer went down the coast past Lisnevin. This made it very difficult for parents and families to visit the boys. The journey took longer, was more expensive and often meant changes of bus and a walk of at least a mile. Dr Lockhart explained that the location also led to a reduction in the number of home visits made by staff.[27] LN 25 told us that when he commenced work in Lisnevin at the Millisle site in 1983 a minibus service was in place to transport family members visiting boys to and from the public bus stop in Millisle to the school.[28]

29 Major programmes of refurbishment were undertaken to make the site at Millisle more appropriate for a training school. However, when the SSI inspected Lisnevin in April 1988[29] inspectors found that because the premises had been built on penal lines it was in many ways unsuitable for use as a Special Unit for adolescent boys that had a philosophy based upon child care considerations.[30] Inspectors acknowledged that the décor had been modified to soften the institutional feel of the buildings, but concluded that despite these improvements there were still problems with the physical provision in Lisnevin.[31]

30 In its closing submission to this module, the DoJ accepted the criticisms about the premises at Millisle being unsuitable for housing a training school. However, it pointed out that the move was necessitated by the outcome of the second public inquiry about the Kiltonga site and that the choice of the Millisle site, which was vacant and contained many of the amenities necessary for a training school, was undoubtedly driven by public expenditure considerations.[32]

Remand Unit

31 Following the closure of the Juvenile Remand Unit, formerly located at the Young Offenders Centre in Hydebank, a ten-bed secure remand unit was opened in Lisnevin in 1985. This meant that boys between the ages of ten and seventeen could be remanded outside of the adult penal system.

32 Dr Lockhart helpfully provided us with a copy of a report the APRU produced of its analysis of admissions to the Remand Unit from 1985 to

27 LSN1238.
28 Day 162, p.87.
29 LSN 13714.
30 LSN 13726.
31 SPT 16268.
32 RGL 90162.

1992. This analysis identified that boys were admitted to the Remand Unit through three routes. Firstly, they were sent from one of the open training schools because it had been decided that their persistent absconding and/or disruptive behaviour was such that placement in a secure setting was required for a period of five weeks. These referrals were scrutinised and adjudicated by an Independent Admissions Panel, chaired by a member of the Lisnevin Management Board and attended by independent representatives from Social Services, APRU and the NIO.

33 It is recorded in the APRU report that out of a total of 1,057 admissions to the Remand Unit between 1985 and 1992, 165 boys were admitted for five weeks: 94 from Rathgael training school and 71 from St Patrick's training school. In 1988, 1989 and 1990 there were significantly lower numbers of admissions from training schools, with ten, fourteen and fifteen admissions respectively in those years.[33]

34 Secondly, and most commonly, boys were remanded to Lisnevin by the courts because of the seriousness of their alleged offence and/or because placement in a secure setting was considered necessary to ensure that a boy was available to attend his next court appearance.[34] Between 1985 and 1992 there were a total of 892 court remands, 361 (40.5%) of which were from Belfast Juvenile, Magistrates and High Courts.[35]

35 Thirdly, with the passing of the Police and Criminal Evidence (Northern Ireland) Order (1989) (PACE) boys could be admitted to the Remand Unit for an overnight remand at the request of the RUC to ensure their appearance at court the next morning. The first admission to Lisnevin under the PACE provisions was on 3 March 1990, and up until the end of 1992 there were 161 cases of boys admitted under PACE provisions.[36]

36 While the annual throughput of the Special Unit was quite low, with most boys remaining there for around fifteen months, there was a higher level of throughput in the Remand Unit, not surprisingly given its remit. The APRU report recorded that from an initial intake of 98 boys in 1985, the admissions increased to a peak of 153 in 1992. The annual admissions varied from 118 to 148, making an annual average of 132 admissions These figures included boys who were re-remanded for the same offence(s) or remanded for subsequent offences.[37]

33 LSN 1311.
34 LSN 1291.
35 LSN 1311
36 LSN 1310.
37 LSN 1289.

37 By 1994, in response to the demand for places, the capacity of the Remand Unit was increased to 25 places. There was a corresponding reduction in the capacity of the Special Unit from twenty beds to fifteen beds.[38] Even with this increase in capacity, the minutes of Management Board meetings record that there were periods that the Remand Unit was filled beyond capacity and that this over-occupancy put considerable strain on the operation and management of the Unit. The impact of over-occupancy was also raised with the NIO. For example, in November 1994, Mr Denley the then director of Lisnevin reported to the NIO that there were 41 boys in the Remand Unit and that this meant that the school was "severely overcrowded".[39] He pointed out that existing staffing levels were inadequate as they were calculated on the basis of 25 boys being accommodated in the Remand Unit and informed officials that boys were having to be locked up during the day as a means of dealing with the situation.[40] There is evidence that the NIO responded to these concerns. At a meeting in February 1995, senior managers reported to NIO officials that the situation had improved and acknowledged that this was due in part to the NIO having written to the courts about the overcrowding problems being experienced in Lisnevin.[41] It is clear from the report of the SSI inspection of Lisnevin in 1988 that it was not just the number of boys on remand in Lisnevin that was creating problems, but also the challenging nature of the behaviour of some of the boys. Inspectors commented:

> "Since the opening of the Remand Unit life has not been without its problems. Disturbances, barricades, damage, fire, assaults on staff and acute problems of control of very difficult behaviour."[42]

Governance

Management Board

38 Lisnevin was managed by a Board of Management which consisted of an independent chairman appointed by the Secretary of State and representatives from the management boards of St Patrick's, St Joseph's, Rathgael and Whiteabbey Training Schools. The DoJ and the DHSSPS explained in their joint statement that these governance arrangements

38 LSN 1287.
39 LSN 13236.
40 LSN 13235.
41 LSN 13241
42 LSN 13747.

were seen as a means of bringing together the expertise and learning of the different training schools.[43]

39 In an arrangement that was unique to Lisnevin within the training school system, the secretary to the board was a member of the senior management team. He had a second line management role equivalent in the hierarchy to the role of deputy director and had particular responsibility for financial management and for supervising the work of administrative, security, maintenance and domestic staff. SSI inspectors who inspected the school in 1988 were impressed with this arrangement and commended it to other training schools.[44] The Management Board established a committee to deal with staffing issues and a member of the board sat on the Admissions Panel that approved admissions to the Special Unit.

40 The minutes of the Management Board show that it exercised oversight of the management, funding and development of the school and also concerned itself with matters to do with the progress of individual boys, for example a boy being released on licence, and how incidents such as boys barricading themselves in rooms were handled.[45]

41 The Management Board was informed about allegations from boys that staff had assaulted them and about complaints by boys, for example that staff had used illegal holds during a restraint. We noted that the Management Board arranged for its staff committee to receive follow-up reports on these matters even when boys had refused to submit a formal complaint or had withdrawn their complaint.[46]

42 The Management Board also considered staffing matters such as the adequacy of staffing levels, staff turn-over, the type and mix of staff required and issues in relation to individual staff, including complaints made against them and grievances submitted by them.[47]

43 The report of the SSI inspection in 1988 reminded the Board of Management that Rule 10 (3) of the Training School Rules required that the school be visited at least once a month by at least one member of the Board of Management who "shall satisfy himself regarding the care of the boys and the state of the school".[48] The inspectors' scrutiny of

43 LSN 941.
44 LSN 13724.
45 LSN 13785.
46 LSN 12981-12982.
47 LSN 13784.
48 LSN 13755.

records showed that during the previous twelve months this duty had only been performed on six occasions. The report of the inspection included a recommendation that the frequency of visiting by board members be increased to comply with Rule 10 (3) of the Training School Rules. By the time of the next SSI inspection visit to Lisnevin in January 1992, inspectors found that monthly visits were being completed, findings were reported to meetings of the management committee and the director was responsible for taking any necessary action. They concluded that board members were carrying out their duties regularly and effectively.[49]

Northern Ireland Office

44 The NIO maintained regular oversight of Lisnevin. Officials met on a monthly basis with the senior staff team and on a quarterly basis with the Management Board. The minutes of these meetings, which were chaired by a NIO official, record detailed monitoring of financial and operational matters, discussion of legislative and policy developments and consideration of what were termed in the agendas and minutes as "sensitive items" which were issues to do with individual boys and staff members.

45 Major incidents such as violent incidents, damage to the school and multiple absconding were discussed, contributory factors identified and remedial action agreed. Although finances were limited and spend controlled, it was clear that where additional funding was required, for example, to repair damage to the building or improve security, it was forthcoming. However, the level and mix of staff, the lack of qualified staff and a dependence on the use of casual staff was a persistent concern, particularly at times when the Remand Unit was overcrowded. The delay in addressing this issue and the impact it had on the operation of the school is considered later in this chapter.

Inspection

46 The DoJ and the DHSSPS explained in their joint opening statement for this module that the training schools inspection functions were transferred from the Ministry of Home Affairs (MoHA) to the Department of Health and Social Services (DHSS) in the early 1970s. The Departments explained that they could not state at the time they submitted their statement

49 LSN 13819.

whether inspections of training schools were undertaken by the Social Work Advisory Group (SWAG) on behalf of the DHSS for the NIO between the early 1970s and early 1980s. They referred to their view that children's homes were not inspected at that time because of the influence of the Seebohm report, which recommended a shift from regulation to the provision of support and advice, and suggested this may have also affected the NIO's approach to inspection of training schools.[50]

47 The first report of an inspection of Lisnevin that was available to us was that undertaken by the SSI, the successor to SWAG, in April 1988.[51] We also considered SSI reports of announced inspections of the school in 1992,[52] 1993[53] and 1994[54] and two unannounced inspections in 1993[55] and 1994.[56] We were also assisted by an overview report *"Residential Child Care in Northern Ireland: the Training Schools"* which the SSI published in 1989. This report provided a helpful summary of the findings of inspections of the training schools including Lisnevin during the period 1987-1988.[57]

48 The report of the 1988 inspection was comprehensive and provided a detailed analysis of the operation of the school. Despite concerns about the physical provision in Lisnevin the inspectors described the regime in the school as having an emphasis on benign/humane containment, which enabled the young people to take part in educational, vocational and recreational programmes.[58] Inspectors made recommendations in this and subsequent inspections about ways in which the conditions for the boys should be improved, some of which we will consider in detail later in this chapter.

Independent Representation Scheme

49 Another form of monitoring was introduced in 1991 when the NIO funded the establishment of an Independent Representation Scheme for children detained in Lisnevin. The Independent Representation Scheme was operated by the Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO) which recruited volunteers to act as independent representatives

50 LSN 949.
51 LSN 13709-13779.
52 LSN 13809-13849.
53 LSN 13850–13872.
54 LSN 13896-13904.
55 LSN 13873-13879.
56 LSN 13905–13911.
57 SPT 16222-19310.
58 SPT 16268.

(IR). These representatives were trained in a range of relevant areas, including child protection. Their role was to listen to the views of young people, to make these views known to management and senior staff within the school and, where possible, to facilitate resolution. We will consider matters boys raised with independent representatives later in this chapter.

Evidence from Applicants about Lisnevin

50 Eight applicants provided evidence in person about Lisnevin: HIA 200, HIA 267, HIA 253, HIA 138, HIA 94, HIA 400, HIA 434, and, HIA 374. Three of these witnesses (HIA 200, HIA 267 and HIA 253) were completely positive about their time in the school.

51 HIA 200 spent five weeks in Lisnevin in 1974 for assessment. He told us: "Lisnevin was fantastic and I have no complaints about my time there".[59] HIA 267 was in Lisnevin for assessment for approximately six weeks in 1975. He had no complaints about the school and told us he enjoyed the activities and the time he spent with the other boys.[60]

52 HIA 253 was in Lisnevin for approximately six months in 1984 and said in his written statement that he found the staff in the school friendly and not really strict.[61] He commented further when he gave evidence in person: "…they tried to make better of you."[62] HIA 253 particularly appreciated being able to earn weekend leave through good behaviour even though Lisnevin was a secure school.

53 We will now consider the evidence from the other five witnesses (HIA 94, HIA 400, HIA 434, HIA 138, HIA 374) and the written evidence of HIA 418 under the headings: physical abuse, sexual abuse, emotional abuse, neglect and unacceptable practices.

Physical Abuse, including Peer Abuse

54 HIA 400 was in Lisnevin for assessment for one month in 1974. He told us in his statement:

> "Apart from being hit around the head a few times, I have no complaints to make about Lisnevin. It was a reasonable place with good staff who, for the most part, were caring and compassionate".[63]

59 RGL 037.
60 RGL 064.
61 LSN 059.
62 Day 142, p.22.
63 Day 152, p.110.

When he gave evidence in person he explained that that there were certain codes of behaviour in Lisnevin and if inmates failed to adhere to them a minority of staff would:

> "shout at you, sometimes slap you on the ears, sometimes hit you over the head with their knuckles."[64]

55 He gave an example of an officer rapping him over the head with his knuckles as punishment for looking down a corridor. HIA 400 was in other institutions and commented that he did not consider that the physical chastisement in Lisnevin was exceptional.[65]

56 HIA 94 was transferred from St Patrick's training school to Lisnevin in November 1973. He remained there until August 1975 and then because of his disruptive behaviour he was transferred to Armagh Prison.[66] In his first written statement, HIA 94 alleged he was beaten in Lisnevin by staff called LN 1 and LN2. He submitted a suplementary statement (dated 12/3/14) in which he corrected this allegation and clarified that LN 1 and LN 2 were fellow inmates and not staff.[67] However, he went on say that three members of staff who he named as LN 10, LN 11 and LN 8 beat him at various times and that a female art teacher who he believed witnessed this abuse did nothing to stop it or help him.[68] He told us when he gave evidence in person that officers beat him in the showers, living room and the cells.[69]

57 It was not possible for the Inquiry to trace and make contact with LN 10 and LN 11 but LN 8 provided a statement. He told us that he was a teacher in Lisnevin and had acted as a joint key worker for HIA 94. He explained that the allocation of two key workers to one boy was unusual and that the arrangement was put in place in response to HIA 94's aggressive and physically violent behaviour.[70] LN 8 stated that he was able to talk to HIA 94 and accepted him into his class when other teachers were reluctant to allow HIA 94 back in to their classrooms after his violent outbursts.[71]

58 Dr Lockhart remembered HIA 94 as one of the most disturbed and violent young people he ever met and also recalled LN 8 telling him that

64 Day 152, p.110.
65 Day 152, p.111.
66 SPT 46116.
67 LSN 005.
68 LSN 009.
69 Day 139, p.152.
70 LSN 872.
71 LSN 873.

the director, LN 6 had given him permission to use "as much force as necessary" to control HIA 94's behaviour.[72]

59 LN 8 refuted without reservation the allegations that he beat HIA 94. He stated that he only remembered one occasion when he was involved in restraining HIA 94 and that was when HIA 94's behaviour had been so frightening to some boys and staff that they had barricaded themselves in a common room for fear of being attacked by him.[73] He referred us to extracts from contemporaneous records maintained in Lisnevin about HIA 94's aggressive and violent behaviour towards other boys and staff.

60 Junior Counsel to the Inquiry discussed these records with HIA 94 when he consulted with him prior to HIA 94 giving evidence in person. The records detailed the considerable difficulty staff in Lisnevin had managing HIA 94's behaviour. They also show that the Management Board had several discussions about how best to deal with HIA 94's behavior, including on one occasion how to respond to an incident where he broke a member of staff's nose.[74] HIA 94 told us that he could not remember the recorded incidents but he acknowledged, "They just couldn't control me".[75]

61 The records also showed that HIA 94 received corporal punishment in Lisnevin. For example, on one occasion he was caned for attacking a member of staff and on another occasion he was threatened with the cane if his public accusations to another inmate that the boy's father was murdered for being an informer were repeated. Both the caning and the threat of caning were recorded.[76]

62 In contrast to HIA 94's evidence, HIA 374, who was in Lisnevin for assessment in 1976 - the year following HIA 94's departure from the school, told us he didn't see anyone in Lisnevin "getting abused, hurt, harmed, shouted at or nothing."[77]

63 HIA 138 was in Lisnevin on remand from March to June 1990 and he told us that he was physically abused during his time there. He described getting into confrontations with staff, which would start with the exchange of verbal abuse and then lead to physical fights. He gave an example of a confrontation which he said occurred because a member of staff who was

72 LSN 1248.
73 LSN 874.
74 Day 139, p.144.
75 Day 139, p.152.
76 LSN 171.
77 Day 140, p.24.

handing out cigarettes (cigarettes were handed out at regular intervals during the day) refused to give him a cigarette and told him he would have to beg for one. HIA 138 said he got into a physical fight with the member of staff, managed to over-power him and made him promise to give him a cigarette and not punish him for fighting. He explained that when he got these assurances he let the member of staff go but that other staff who had come to see what the commotion was about assaulted him and he ended up on the ground being kicked and punched by them.[78]

64 HIA 138 also said that during restraints officers pressed pressure points on his body which had a paralysing effect and that it took time for feeling to return to his arms and legs. One of the methods that staff used to deal with disruptive behaviour was to remove a boy and put him in isolation. HIA 138 told us that staff regularly beat him as they were taking him to the isolation unit, and that on one occasion by the time he was left in the separation cell he was bleeding from his nose and had excrement all over his pyjamas because he had soiled himself.[79]

65 He also described an incident when he and another boy barricaded themselves in a room and were too scared to come out for fear of being beaten by officers. He recalled that a member of staff, LN 29 intervened and promised they would not be hurt if they came out and that he kept that promise.[80]

66 When HIA 138 gave evidence in person he was shown extracts from logs maintained in Lisnevin which recorded that he was placed in the separation unit for such behaviour as flooding his room, barricading himself in a room with another boy and wrecking that room, and hitting another boy.[81] The records also showed that there were times that HIA 138 was sent to bed early or made to stay in his bedroom during the day in response to his behaviour and that he was not always placed in the separation unit. Although HIA 138 could not remember the specific incidents that were recorded he did accept that the type of behaviour described did take place and that he and other boys would have been difficult for staff in Lisnevin to manage.[82]

78 LSN 031
79 LSN 031.
80 LSN 032.
81 Day 156, p.15 to16 and LSN 21451.
82 Day 156, p.10.

67 HIA 418 was remanded in Lisnevin on the first occasion from 18 September 1992 to 18 December 1992 and on the second occasion from 10 April 1993 to 21 April 1993. He commenced a third period in Lisnevin on 15 December 1995, but only sixteen days of that stay are within the years of the Inquiry's terms of reference. In his written statement, HIA 418 described being regularly intimidated and bullied by staff in Lisnevin and that when he tried to stand up for himself he was restrained by staff. He described staff putting his arms up his back and that the pain was so excruciating he screamed and pleaded for the restraint to stop.[83] He told us that he observed other boys being treated in the same way.[84]

68 HIA 418 also described a member of staff kicking him because he thought HIA 418 was laughing at him rather than at the joke he had told, and another member of staff, who played rugby, tackling him to the ground at an outdoor event and leaving him winded.[85]

69 HIA 418 stated that he did not remember the names of the staff that restrained him but that he remembered LN 25 being in charge of staff and believed he must have been aware of their behaviour.[86] LN 25 provided a written statement and gave evidence in person. He explained that he developed a rapport with boys that assisted him to diffuse situations but accepted that not all staff may have been able to do so. He confirmed that restraint techniques were used but he denied that were used to intimidate, bully or assault residents[87] and he stated more generally that he did not witness and was not party to any culture of intimidation or bullying by staff.[88]

Complaints Processes

70 LN 25 pointed out that complaints processes were available to boys if they felt they were being treated unfairly.[89] When he gave evidence in person he confirmed that a previous inmate who had been on remand in Lisnevin made a complaint about him. He explained that the complaint was referred to the police and the DPP but that he was not required to appear in any disciplinary or court proceedings in relation to it, and he was

83 LSN 026.
84 LSN 027.
85 LSN 026.
86 LSN 026.
87 LSN 1225.
88 LSN 1224.
89 LSN 1225.

just told by his manager that no further action was being taken in relation to it.[90]

71 It is clear from documentation we have seen that boys were given clear advice on admission about their right to complain if they felt they were being treated unjustly or that their rights were not being protected, and the procedure for doing so.[91] Minutes of the Management Board show that it was informed about formal complaints from boys and minutes of the meetings between senior managers and NIO officials show that complaints and how they were being handled were discussed with NIO officials. For example, at the meeting with the NIO officials in November 1993 Mr Gordon, who was the board secretary as well as a member of the senior management team, informed officials that two complaints from boys about assaults by staff had been referred to the RUC for investigation. He confirmed that the RUC had found no case in relation to one of the complaints but had referred the other complaint to the DPP for an independent assessment of the available evidence.[92]

72 However, a review by NIACRO's Youth Justice Unit of complaints received during the operation of the Independent Representation Scheme in Lisnevin provided more evidence of boys complaining about physical abuse by staff and also highlighted that there was not a consistent approach taken to referring complaints to appropriate bodies for investigation.

Review of the Independent Representation Scheme

73 The review covered the period 1994 to 2000, but in accordance with the Inquiry's terms of reference we only considered the period 1994-1995. During 1994 to 1995 Independent Representatives (IRs) received eleven complaints from individual boys and two general complaints from groups of boys, one about having to go to bed early and one about lack of privacy in the shower.[93] The complaints from individual boys were about alleged assaults by staff, verbal abuse by staff and bullying by other boys.

74 For example, one boy made two complaints to an IR in August 1994 about alleged physical abuse by staff. He made his first complaint on 8 August 1994. He told the IR that when he was being restrained by two members of staff, one of the staff punched the right side of his head and

90 Day 162, p.110.
91 LSN 12360.
92 LSN 13176.
93 LSN 14379.

his head was banged off the wall and floor. He said he was taken to the nurse but did not remember what treatment he received. Although the boy's account of how he was treated during the restraint was corroborated by another boy he was reluctant to make a formal complaint. He made his second complaint on 24 August 1994. He told an IR that a member of staff had put him on the ground and punched him leaving marks to his upper eye. However, he went on to explain that he had been "winding up" the member of staff and did not wish to make a formal complaint. Another boy complained to the IR on 24 August 1994 that when he did not respond quickly enough to an instruction to get undressed for bed a member of staff grabbed him around the throat causing him to choke and then kicked him on the ankles and punched him in the stomach.[94]

75 The IR coordinator wrote to the director of Lisnevin about these complaints. The director responded but said he was unable to investigate the two complaints of physical abuse from the first boy as he had left Lisnevin before they were brought to his attention. He explained that he had personally investigated the complaint from the other boy and had been unable to prove or refute the allegation but had advised the boy that he could meet with a member of the Management Board to discuss his complaint. He indicated that the boy was thinking about whether to do that.[95]

76 NIACRO's Youth Justice Unit noted in its review that despite the serious nature of these complaints they were all dealt with internally by Lisnevin and none were referred to social services or the police.[96] A further review of the Independent Representation Scheme was completed in 2000 and Ronnie Orr of the SSI, who was involved in it, concluded that a number of cases referred to the IRs "did not seem to have been properly concluded".[97]

77 This evidence suggests that although complaints procedures were available to the boys and there were related policies for how staff should handle complaints these were not always fully implemented. We consider that the two complaints the director told the IR coordinator he could not investigate because the boy in question had left Lisnevin were allegations of serious assault that should have been followed up in order to ensure that if they were true the staff member in question could be prevented from behaving

94 LSN 14394-14395.
95 LSN 14396.
96 LSN 14396.
97 LSN 14462.

in a similar manner towards other boys. **We consider the failure of the director to refer these complaints to the RUC was indicative of a systemic failing to take all proper steps to prevent, detect and disclose abuse.**

Physical Restraint and Staff Training

78 The contemporaneous records from Lisnevin detail staff having to deal with a range of disruptive, provocative, destructive and, at times, violent behaviour from boys, including riots involving a number of boys acting together.[98] The behaviour included boys barricading themselves in rooms, destroying furniture and fittings, flooding rooms, starting fires and fighting with each other and with staff. The DoJ pointed out in its closing submission that, given the range of behaviour boys were displaying, it is reasonable to infer that staff were bound to resort to physical intervention to defend themselves or to protect others from physical harm.[99]

79 There is an inherent risk in the process of restraining and moving a struggling and resisting teenage boy that the boy and/or the staff will be hurt. It would appear this happened on occasion in Lisnevin. For example, we considered documentation about an investigation into a restraint in Lisnevin that resulted in a boy's collar bone being broken and a staff member being admitted to hospital with chest pains.[100]

80 One of the most effective means of reducing the risk of a young person and/or staff member being hurt is ensuring that staff are properly trained in diffusing situations and in restraint and control methods. We noted that in the report of a working group set up to consider an incident at Lisnevin on 23 December 1986 where boys set fire to their mattresses and six boys absconded, it was recorded that no formal training had been given to staff in the matter of "physically controlling difficult boys".[101] The DoJ acknowledged in its closing submission that formal training for staff in the application of appropriate restraint measures was too long delayed and it accepted that some staff may have used inappropriate techniques to restrain boys.[102] However it also pointed out that even in the absence of such training, staff would have been aware that to beat a boy when taking

98 LSN 12984.
99 RGL 90174.
100 LSN 1538.
101 LSN 14499.
102 RGL 90176.

him to the punishment block (as HIA 138 said happened to him) was unacceptable and would have resulted in disciplinary action had any such abuse been detected.[103]

81 From the evidence we have considered, we are satisfied that some staff may have relied on restraint methods to maintain discipline in the face of disruptive behaviour and that during some restraints force was used that led to boys being hurt. We consider this was particularly the case when staff were faced with persistent poor behaviour from some boys, were frustrated about the damage caused by boys and were anxious to be seen to maintain control and authority. We also consider that the risk of harm was much greater when boys robustly resisted being restrained. However, taking account of all the evidence we have heard we do not consider that the use of excessive force by staff in Lisnevin was so widespread as to amount to systemic abuse.

82 **We considered that inadequate training in control and restraint methods increased the risk of staff behaving inappropriately and boys being hurt. Therefore, we found the delay in providing this training amounted to a systemic failing by the Management Board of Lisnevin and the NIO to ensure the institution provided proper care.**

Peer Abuse

83 HIA 418 complained that he was intimidated and bullied by other boys, and staff did not intervene to protect him. Contemporaneous documentation records HIA 418 complaining to LN 25 on 21 October 1992 about being bullied and asking to be moved to a different class. LN 25 recorded the complaint and asked staff to "keep an eye on this situation". When LN 25 gave evidence in person he said he could not remember this complaint but indicated that in addition to alerting other staff to HIA 418's concerns about being bullied, he believed he would have discussed the possibility of moving HIA 418 to a different class with the deputy director of education, as it would have been for him to agree such a transfer.[104]

84 HIA 434 spent two and a half months on remand in Lisnevin from February to May 1989. He told us that the regime was very strict and regulated, and that autonomy in relation to basic decision making was taken from him but that generally the quality of care was good.[105] He told us that in

103 RGL 90176.
104 Day 162, p.101.
105 LSN 039.

his experience staff did intervene to stop fighting between boys and that he was not bullied in Lisnevin.[106]

85 Information about the work of the Independent Representation Scheme also provides an example of staff dealing with bullying. In October 1994 a boy told an IR that he was being threatened by other boys and when the IR reported this to managers in Lisnevin they agreed to take appropriate steps to ensure the boy's safety. Two days later, the same boy showed the IR self-inflicted injuries and when this was reported to senior managers they arranged a meeting with a psychologist for the boy and told staff to be vigilant in relation to him.[107]

86 The evidence we have heard suggests that bullying and fighting between boys, which might be expected in an institution like Lisnevin particularly during times of social unrest in the wider community, was taken seriously and staff intervened to address them.

Sexual Abuse

87 We received no complaints about sexual abuse in Lisnevin. HIA 374 who was in Lisnevin in 1976 told us in his written statement[108] that when he was showering, a male member of staff placed his hand on his private parts and told him "no masturbating". When HIA 374 gave evidence in person he explained that on reflection he considered this inappropriate rather than abusive behaviour and that he did not believe the member of staff got sexual gratification from what he did.[109]

Emotional Abuse

Sectarian Abuse

88 HIA 138 told us he was subject to sectarian abuse by staff and other residents. He said he was picked on by staff because he had the initials of a paramilitary organisation tattooed on his hand. He said this led to staff calling him insulting names and being verbally abusive to him and that it was a "culture of abuse" with over half of the staff on duty at any one time being verbally abusive to him.[110]

106 LSN 039.
107 LSN 14396-14397.
108 SPT 119.
109 Day 140, p.13.
110 LSN 030.

89 He particularly recalled a member of staff, LN 28, who was in charge of the woodwork shop. He said LN 28 would regularly verbally abuse him and say he would like to cut off HIA 138's fingers. HIA 138 took this to be a reference to getting rid of the tattoo on his hand. HIA 138 told us that he did not complain about the behaviour of staff because at first he did not know the procedure for complaining and when he did he decided that there was no point in complaining as it would make no difference.[111]

90 HIA 418 said that he was subject to sectarian abuse from other residents and staff and he referred to a particular member of staff, (LN 26) wearing Rangers football club t-shirts and jewellery to work. He also stated that LN 25 would tell him and other boys during snooker matches not to play shots called crosses and he thought "this was referring to our Catholic identity".[112] LN 25 expressed his surprise at this allegation. He explained that "crosses" was a common term used in the snooker fraternity to describe a particular shot and that was the only context in which he used it.[113]

91 The evidence of HIA 138 and HIA 418 about sectarian behaviour from staff in Lisnevin contrasted with the evidence we heard from HIA 434 and HIA 253. HIA 434 described "fights on an almost daily basis between Catholic and Protestant inmates in Lisnevin"[114] and recalled that staff intervened to stop the fighting. He confirmed when he gave evidence in person that he never observed staff being sectarian in their behaviour.[115] HIA 253 also confirmed when he gave evidence in person that he did not witness staff in Lisnevin being sectarian.[116]

92 When LN 25 gave evidence in person he said he was not aware of a culture of sectarianism in Lisnevin and confirmed that he would have made it clear to boys that he would not tolerate sectarian behaviour.[117]

93 Consideration of Lisnevin records provided examples of staff dealing with sectarian issues, for example staff isolating and then restraining a boy who refused to stop singing loyalist songs.[118] The director, Mr Denley informed the Management Board about a complaint from a boy

111 LSN 030.
112 LSN 027.
113 LSN 1226.
114 LSN 039.
115 Day 153, p.122.
116 Day 142, p.19.
117 Day 162, p.102.
118 LSN 1538.

that a member of staff had made a sectarian remark to him, even though the boy had withdrawn his complaint. The director shared his concern about the sudden retraction of the complaint and the Management Board agreed that the situation would have to be monitored closely.[119]

94 When Dr Lockhart gave evidence in person he referred to a research study he completed in Lisnevin which showed that the experience of mixing together during five-week assessment periods led Catholic and Protestant boys to realise they were more alike than different and that this perception persisted after they completed their assessment period.[120]

95 We consider it inevitable that the social unrest and sectarianism in the wider community at the time would have influenced the attitudes and behaviour of some boys and some staff in Lisnevin. However, the evidence we have received does not indicate that sectarian behaviour by staff was systemic or condoned by managers.

Abusive Comments

96 In addition to the evidence we heard about sectarian abuse, we noted that a boy complained to an IR in August 1994 that a member of staff had made abusive comments about his mother.[121] This complaint was referred to the governor, but he told the IR coordinator that he was unable to investigate it because the boy had left Lisnevin before the matter was brought to his attention.[122]

97 We also noted how HIA 13 compared the behaviour of a member of staff LN 29 with that of other staff: "where the other staff would have been kind of goading us and making fun of us and stuff like that, he wouldn't."[123]

Humiliation

98 HIA 138 told us that he was made to wear pyjamas when his father came to visit and when he queried this he was told by the member of staff that he had to earn the right to wear his ordinary clothes. HIA 138 said he found this treatment humiliating and that he felt singled out as none of the other inmates were treated in the same way.[124]

119 LSN 12987.
120 Day 161, p.57.
121 LSN 14395.
122 LSN 14396.
123 Day 156, p.25.
124 LSN 032.

Right to Privacy

99 We found evidence of action being taken to protect the rights of boys. In November 1990 a team leader reported that three members of staff had "acted unprofessionally in relation to a client's right to privacy". This matter was investigated, disciplinary action was instigated and formal warnings were issued to the staff.[125]

100 On the basis of the evidence we have received we have concluded that there was no systemic emotional abuse in Lisnevin.

Neglect

Physical Environment

101 The SSI commented in the report of its 1988 inspection of Lisnevin on the lack of furniture in the boys' bedrooms. As a result of bedroom furniture being deliberately damaged and destroyed only two pieces of furniture were provided, a cuboid which could be used as a chair or a table and a reinforced mattress which rested on the floor without a supporting frame. As there were no wardrobes in the bedrooms, the boys had to place their day clothing on the corridor floor, outside their bedrooms, during the night. The inspectors acknowledged the risk of furniture being vandalised but pointed out that boys held in a caring regime should only be deprived of normal home comforts in exceptional circumstances, and even then only for a short period of time. They recommended that appropriate furniture and clothing space was provided.[126] We noted that when Lisnevin was inspected in 1992 inspectors recorded that a major effort had been made to improve the quality of accommodation in the Special Unit but they found the bedrooms in the Remand Unit quite spartan and devoid of any sense of identity.[127] We agree with the inspectors' views about the accommodation provided for the boys. Although it is clear from Lisnevin records that some boys caused considerable damage to their bedrooms we consider the lack of furnishing, and in particular the lack of provision for storing clothes, was unacceptable. **We consider that accommodating boys in this way was a systemic failing by the Management Board and the NIO to ensure the institution provided proper care.**

125 LSN 12967.
126 LSN 1279.
127 LSN 13824.

Medical Attention

102 Dr Lockhart told us Lisnevin had a fully equipped medical room and employed three nurses, and that usually at least one of the nurses was on duty between the hours of 9am and 9pm each day. In addition, a local GP acted as medical officer and visited at least once per week or otherwise on demand.

103 He explained that each boy had a full medical on admission and that the nurses dealt with minor medical complaints and ailments. We noted references in the contemporaneous records to boys being taken to the nurse and to Ards Hospital for treatment of injuries[128] and of HIA 94 being sent to Muckamore Hospital for three short stays for assessment. Dr Lockhart also recalled a full dental room and that an outside dentist visited on a weekly basis. He recalled that it was noted that many boys' teeth were in a poor state when they arrived in Lisnevin and in a better state by the time they left.[129]

104 HIA 138 said in his written statement that he was quite bruised following what he described as a punishment beating and a nurse came to the cell where he was being held to check on him. He said that she looked at him, laughed and walked out commenting to other staff that were present that he would live, which made them laugh. HIA 138 commented "I could not believe someone who was supposed to help me could be so callous."[130]

105 When HIA 138 gave evidence in person he emphasised that he received no treatment for injuries caused to him by staff. He pointed out that there was detailed recording of treatment he received for minor ailments such as acne and an upset stomach:

> "but there is no record of the injuries to my face when I was taken to the separation unit, you know, because there always was, like. There was always blood, you know."[131]

106 HIA 434 said in his written statement that he was so cold in his room that he slept beside the radiator pipes and on one occasion burnt his arm on the pipes. He stated that staff laughed off his injury and failed to provide him with medical treatment.[132] When he gave evidence in person, HIA 434 clarified that he did receive treatment but not until a new shift

128 LSN 1538.
129 LSN 1232.
130 LSN 032.
131 Day 156, p.32.
132 LSN 039.

of staff came on duty and by that time his wound had started weeping and sticking to his clothes.[133] Lisnevin records detail HIA 434 receiving treatment for a small burn on his arm on 17 March 1989 and 29 March 1989.[134]

107 Apart from the inadequate furnishing in boys' rooms, and in particular the lack of storage facilities for clothes, we did not find evidence of systemic neglect in Lisnevin.

Unacceptable Practices

108 Putting boys in isolation was a regular response to disruptive and violent behaviour in Lisnevin. For minor offences boys might be confined to their bedrooms but for more serious misbehaviour they would be placed in a separation unit. Dr Lockhart recalled that on the Millisle site there were six isolation rooms located together with a small office beside them in an isolated part of the ground floor of the main building.[135]

HIA 138 described an isolation room:

> "The cell had high barred windows and there was no furniture in it. At night the staff would give me a blue mattress to sleep on but it was taken out every day."[136]

109 LN 25 told us in his statement that the separation unit was used to provide "time out" when a young person became so violently disruptive, disruptive and/or out of control as to represent a danger or disruption to staff members, fellow residents or himself. He explained that separation was used to give boys time and space to calm down.[137] However, we noted that some witnesses referred to the separation unit as the punishment block, and that term was also used in the Lisnevin policy documents.[138] We infer from this that both staff and boys in Lisnevin would have viewed confinement in the unit as a punitive measure not just as a means of enabling a boy to calm down. In this section we will use whichever term for the unit the witness used.

110 When LN 25 gave evidence in person, he told us that he could not recall senior staff approving the use of the separation unit for a boy in advance of his removal to it. The usual course of events was that a volatile incident would happen, staff on duty would decide separation was necessary,

133 Day 153, p.123.
134 LS 21290-21291.
135 LSN 1240.
136 LSN 031.
137 LSN 1224.
138 LSN 13738.

remove the boy and then report the matter to senior staff.[139] LN 25 estimated that 70% of removals would be for short periods and in the other 30% of cases boys would be separated for a morning or an afternoon, sometimes overnight and on rare occasions for up to two days.[140]

111 Dr Lockhart told us that his office on the Millisle site was near the separation unit and that he remembered boys ringing a buzzer for assistance and on some occasions having to wait considerable time before they received it. However, when LN 25 was asked about this he said that if senior staff approved the use of the separation unit they would allocate a member of staff to sit in the office in the unit to look after the young person's needs.[141] The DoJ acknowledged these different views from former staff about the operation of the separation unit, but pointed out that these staff members did not work for very long together at the Millisle site.[142]

112 Three witnesses complained about the use of the separation unit in Lisnevin. HIA 94 was resident in Lisnevin at Kiltonga and he told us that during a twenty-month stay in the school he was kept in a secure cell every night and sometimes during the day.[143] Dr Lockhart explained that because HIA 94 regularly got into fights with other boys it was decided that it was not safe for him to share a bedroom because of the danger of "significant violence", and as there were no single bedrooms for boys in Kiltonga one of the cells in the separation unit had to be used.[144] He accepted that this arrangement was not ideal but explained that to mitigate the situation somewhat HIA 94 was allowed to paint the room and personalise it and he was allowed a later bedtime.[145]

The DoJ confirmed that Lisnevin records show that HIA 94 was also put in isolation during the day in response to his behaviour, but that although there were times these confinements were for a day, they were usually for no more than a few hours at a time, with the shortest recorded confinement being for ten minutes.[146]

113 HIA 138 told us that he had frequent stays in the separation unit. When he gave evidence in person he first said he was detained for "short periods

139 Day 162, p.114.
140 Day 162, pp.115 to 116.
141 Day 162, p.113.
142 RGL 90184.
143 LSN 005.
144 Day 161, p.77.
145 Day 161, p.64.
146 RGL 90181.

of time"[147] but responding to questioning later in the hearing he said that he thought he was usually detained overnight as he could not remember being brought to the separation unit and returned to the group on the same day.[148] He confirmed that he had access to food and drink and to the toilet in the separation unit.[149]

114 The DoJ reviewed the records relating to HIA 138 and found he was removed to the separation unit on one occasion for assaulting another resident[150] and on another occasion because he had barricaded himself in his room and proceeded to destroy lighting and windows in the room.[151] A member of staff recorded on that occasion "staff reported that [HIA 138] is becoming unmanageable."[152] HIA 138 was later charged with causing criminal damage in relation to this incident.[153] The records also showed that other approaches were taken to managing HIA 138's behaviour such as confining him to his bedroom[154] and requiring him to go to bed early on three nights.[155]

115 HIA 418 said in his statement that he was placed in the punishment block ten to fifteen times in Lisnevin and that he felt "total despair and suicidal" when he was there.[156] The DoJ responded to HIA 418's evidence in its closing submission and explained that from a review of the comprehensive records available about HIA 418's time in Lisnevin it appears that although he was the subject of separation on quite a few occasions he was not placed in the punishment block. The DoJ listed five entries in the Lisnevin records of HIA 418 being separated from the group and placed in his bedroom, three entries about him being required to go to bed early, and one entry about him being removed from class. They noted one ambiguous entry which referred to HIA 418 being "removed from the group" but pointed out that did not record him being placed in the punishment block.[157]

116 HIA 418 also said that he was given very little to eat and drink when he was in a punishment cell.[158] LN 25 refuted this claim and was adamant

147 Day 156, p.23.
148 Day 156, p.34.
149 Day 156, p.35.
150 LSN 21451.
151 LSN 21460.
152 LSN 21459.
153 LSN 20782.
154 LSN 21437.
155 LSN 21446.
156 LSN 026.
157 RGL 90182.
158 LSN 026.

that the same meal routine applied to those held in separation as applied to the rest of the Lisnevin population and that occupants would be served the same quantity and quality of food as the rest of the boys. He explained that the only difference was that plastic trays and cutlery were used to prevent boys doing any harm to themselves.[159]

117 Dr Lockhart contrasted separation being used as a punishment on the Kiltonga site and as a control mechanism at Millisle. He explained that in Kiltonga separation was used as punishment, for example for absconding, and boys understood it to be a punishment and knew how long they would be separated from the group.[160] In his view, its use a control mechanism in Millisle meant that boys might be kept in isolation for longer periods and in some cases for "quite a while".[161]

118 He told us that he raised concerns with senior managers in Millisle about the over-use of separation and although they acknowledged it was an issue they did not appear to take action to address the matter.[162] It is clear from the reports of SSI inspections of Lisnevin at Millisle that inspectors shared Dr Lockhart's concerns about the use of separation.

119 In the report of the first SSI inspection of Lisnevin in 1988 inspectors raised concerns about the overuse of separation from the main group as a sanction. They pointed out that Rule 39 (d) of the Training Schools Rules provided that separation "shall only be used in exceptional circumstances" and where a separation was to be continued for more than 24 hours the written consent of a member of the Board of Management shall be obtained and the circumstances reported to the Ministry. Inspectors found that the guidelines about the application of sanctions drawn up by managers in Lisnevin to ensure that staff took a consistent approach to inappropriate behaviour had not taken account of Rule 39 (d).[163] When they examined the records held in the Special Unit they found that separation of boys for periods of more than 24 hours occurred frequently. They highlighted the example of a boy spending two periods in the punishment block, one of 82.5 hours and one of 72 hours, i.e. 154.5 hours in total, which were only separated by a 14-hour period, most of which he spent locked in his own bedroom.[164]

159 LSN 1225.
160 Day 161, p.73.
161 Day 161, p.75.
162 Day 161, p.74.
163 LSN 13738.
164 LSN 13739.

120 By the time of the next inspection in January 1992 inspectors recorded that all instances of separation had to be authorised by a senior residential social worker or the unit administrator and that the records of separation were clearly and regularly scrutinised by the deputy director. The inspectors were satisfied with the recording of the removals and satisfied that the reasons for removal were justified. They commented that they were pleased to note a reduction in the incidence of removal, particularly in the Remand Unit.

121 The monitoring of this aspect of practice continued, and inspectors made adverse comments in the report of an unannounced inspection in 1993 about the introduction of standard sanctions which allowed for automatic removal from the group for a set period of hours as a response to specific transgressions. The inspector commented that the application of such sanctions sat at the level of senior residential social worker rather than requiring consideration and signing-off by a member of the senior management team. He observed:

> "The notion that removal from the group should be the exception and even then for the shortest possible periods seems to have been replaced with removals which can in some instances be the longest allowed under the Training School Rules dating back to 1952."[165]

He acknowledged that the approach did not contravene the Training School Rules but suggested that it was a matter that should be discussed between management of Lisnevin, SSI and the NIO.[166]

122 The inspector recognised that standard sanctions as a means of control were introduced by a depleted senior management team as a means of assisting understaffed teams to manage the behaviour of a large group of delinquent youths. However, he observed:

> "…increased sanctions in the hands of unskilled staff does not seem to be the best recipe for ensuring the best possible care of young people who quite naturally do not want to be where they are and who will misbehave from time to time."[167]

123 At the time of the next regulatory inspection in January 1994 it was reported that sanctions such as removal from the group seem to be

165 LSN 13876.
166 LSN 13870.
167 LSN 13877.

used as "the main means of controlling unacceptable behaviour".[168] The inspector expressed the view that although managers in the school had made efforts to bring about improvements in the application of sanctions, including removals, "unless the fundamental problem of staffing is tackled such efforts are likely to have limited success".[169] The inspector pointed out that the need to develop a core of permanent, experienced staff in Lisnevin had been highlighted in successive SSI reports but to date the situation remains unchanged:

> "Senior management and the Board are aware of the shortcomings of the present staffing situation but little action has been taken to change it."[170]

The inspector indicated that financial constraints had been advanced as the main problem which prevented the appointment of appropriate levels of trained and experienced staff.

124 We saw no response by the management of Lisnevin to these comments, but inspectors who made an unannounced inspection visit to the Special Unit in 1994 found no boys in separation and examination of the records showed that although separation had been used earlier in the day it had been for short periods. Inspectors recorded that the senior residential social worker on duty indicated that separation appeared to be less used as a sanction.[171]

125 In its closing submission to this module the DoJ accepted that what emerged from the SSI reports was that separation was not always used appropriately in Lisnevin and that inadequate staffing contributed significantly to the adoption of the tariff approach of applying standard sanctions as a means of maintaining control and order. The DoJ also accepted that the staffing issues should have been capable of resolution, but stated that at this remove it was not possible to fully explain why they were not more speedily resolved.[172]

126 We are satisfied from the evidence we have heard that in Lisnevin separation was regularly used as one of a range of responses to difficult and disruptive behaviour and that during periods of understaffing it became the main means of maintaining control, particularly in the Remand Unit.

168 LSN 13903.
169 LSN 13899.
170 LSN 13899.
171 LSN 13908.
172 RGL 90179.

The introduction of the tariff system and the associated reduction in managerial involvement and oversight of use of separation was particularly concerning. **We consider it amounted to a systemic failing by the management of Lisnevin and the NIO to ensure the school provided proper care.**

127 **The failure to address inadequate staffing levels, which were clearly having an impact on the daily experience and care of the boys, amounted to a systemic failing by the management of Lisnevin and the NIO to ensure the school provided proper care.**

128 SSI inspectors raised other issues about the treatment of the boys in their 1988 inspection of Lisnevin. They were concerned about the regular periods of lock-up used during the day in the Remand Unit. They recorded that the policy of lock-up developed when the Unit opened because some staff considered it necessary as a means of controlling the group of boys in the context of inadequate levels of staffing.[173] Inspectors recommended that senior managers should review the policy. They also recommended that the practice of keeping boys admitted to the Remand Unit locked up for the first 48 hours and requiring them to wear pyjamas in that period should be stopped.[174]

129 In December 1989, the then Director of the school, Mr McCloskey, wrote to the SSI to confirm what action had been taken to address the recommendations in the inspection report. He confirmed that the use of lock-up in the Remand Unit had been reduced by 50% and that the situation was being reviewed by management with a view to a further reduction.[175] He also confirmed that the boys were no longer locked up on admission to the Remand Unit except in exceptional circumstances.[176]

130 It is clear that inspection by the SSI had a significant impact on the regime in Lisnevin and led to an improved experience for the boys, particularly those in the Remand Unit. We consider that inspections of Lisnevin in the 1970s and 1980s could have enabled these and other improvements to be put in place earlier. **Therefore, we consider the lack of inspection of Lisnevin from when it opened in October 1973 until the first inspection by SSI in April 1988 to be a systemic failing by the NIO to ensure that the school was providing proper care.**

173 LSN 13743.
174 LSN 13767.
175 LSN 13791.
176 LSN 13792.

131 Dr Lockhart commented in his statement on the arrangements for staff leave over the summer period in Lisnevin. He told us that that each summer the teaching staff were on holiday in July and August and the bulk of care staff had some annual leave. He explained this meant that instead of a staff of eight care and teaching staff (plus a senior assistant in charge of the team) there were typically only two permanent staff on duty on each shift. The rest of the team was made up of temporary staff employed for the summer, most of whom were students on holiday from their courses and some of whom were local people. Dr Lockhart told us these staff received no induction training and he commented that this arrangement, which meant "temporary staff were expected to look after and amuse some of the most disturbed children in Northern Ireland", did not work.[177]

132 We accept that staff needed to be able to take annual leave and many will have wanted to take it during school holidays. However, we considered that approval of leave should have been managed in a manner that did not reduce the levels of permanent staff in the significant manner described by Dr Lockhart. We found it particularly concerning that this reliance on casual staff occurred during the summer months at a time when it could be anticipated that more boys might be admitted to the school and that tensions of a sectarian nature might be heightened amongst existing inmates. **We consider these staffing arrangements in the summer months amounted to a systemic failing by the management in Lisnevin to ensure the school provided proper care.**

Conclusions

133 We have heard evidence from nine applicants about the time they spent in Lisnevin, and while four (HIA 94, HIA 138, HIA 275 and HIA 418) were very critical about how they were treated, the other five were, in the main, positive about the time they spent in the school. We have considered contemporaneous documentation that shows the level of disturbed behaviour that some boys exhibited and it is clear that their behaviour attracted more staff attention and led to regular restraint, removal and separation.

134 After careful consideration of all the evidence we received about Lisnevin we have found systemic abuse with regard to the following aspects of the management, oversight and regulation of the school.

177 LSN 1240.

Findings

135 We found:

(1) The lack of schooling from September 1981 to May 1982 amounted to a systemic failing by the Lisnevin Management Board, the NIO to ensure the institution provided proper care.

(2) We consider the failure of the director to refer allegations of the assault of a boy by staff to the RUC was indicative of a systemic failing to take all proper steps to prevent, detect and disclose abuse.

(3) The delay in providing adequate training for staff in control and restraint methods amounted to a systemic failing by the Management Board and the NIO to ensure the institution provided proper care.

(4) Accommodating boys in bedrooms with limited furnishing and making them store their clothes in the corridor outside their bedroom amounted to a systemic failing by the Management Board and the NIO to ensure the institution provided proper care.

(5) The use of a tariff system of standard sanctions, and the associated reduction in managerial involvement and oversight of use of separation, amounted to a systemic failing by the Management Board and the NIO to ensure the school provided proper care.

(6) The failure to address inadequate staffing levels which were clearly having an impact on the daily experience and care of the boys amounted to a systemic failing by the Management Board and the NIO to ensure the school provided proper care.

(7) The lack of inspection of Lisnevin from when it opened in October 1973 until the first inspection by the SSI in April 1988 to be a systemic failing by the NIO to ensure that the school was providing proper care.

(8) The leave arrangements during the summer months, which led to a dependence on casual staff, amounted to a systemic failing by senior managers to ensure the school provided proper care.

Chapter 16:

Module 7 – Hydebank Young Offenders Centre

Introduction

1 During Module 7 we heard evidence from four witnesses who were admitted to Hydebank Wood Young Offenders Centre (Hydebank) during the period 1983 to 1990. HIA 275 referred to his time in Hydebank in his statement but we left his evidence out of account as he failed to appear to give evidence in person or to provide a reason for not doing so.

2 We also heard from Maxwell Murray who commenced work as the deputy governor of Hydebank on October 1984 and remained there until April 1987. He acted as governor of the facility for most of the last two years he worked there. Mr Murray provided a very full and helpful statement to the Inquiry and appended exhibits of relevant documentation, for example guidance provided to officers about what type of clothing inmates should be allowed to wear,[1] and how they should report incidents and occurrences.[2] His statement and exhibits amounted to 1,202 pages. We are grateful for the detailed background information Mr Murray provided about how Hydebank operated in the period he worked there and for his responses to the evidence witnesses gave about their time in Hydebank. We also received a helpful statement and exhibits about the use of control and restraint techniques in Hydebank from Mr David Dowds of the Northern Ireland Prison Service.

3 We were assisted by a joint statement for this module provided by the Department of Justice (DoJ) and the Department of Health and Social Services and Public Safety (DHSSPS) and a closing submission provided by the DoJ. We considered response statements to the evidence of witnesses from the DoJ, the Health and Social Care Board (HSCB) and from a former prison officer HB 4 who responded to specific allegations made against him.

Establishment of Hydebank

4 Hydebank opened in June 1979 on the outskirts of Belfast, some four miles from the city centre.[3] Hydebank was established and operated under the provisions of the Treatment of Offenders Act (Northern Ireland) 1968 (the Act). The purpose of Young Offenders Centres was to enable the removal of young offenders, other than those sentenced for the most

1 HYD 1469.
2 HYD 1311.
3 HYD 471.

serious offences, from the adult prison environment. The Act provided for male offenders between the ages of sixteen and 21 years who had been sentenced to a custodial sentence of less than three years to be detained in a Youth Offenders Centre.

5 The DoJ and the DHSSPS explained in their joint statement for this module that Hydebank was a Category C prison, which meant it was a low security closed prison for people who could not be trusted in an open prison but were considered unlikely to make a determined escape attempt.[4]

6 The Children and Young Persons Act (Northern Ireland) 1968 also applied to the operation of Hydebank. Section 72 (3) of that Act provided that a boy under seventeen years of age could not be sentenced to a Young Offenders Centre unless a court certified him to be so unruly or depraved that no other method of dealing with him was appropriate.[5] The DoJ and the DHSSPS confirmed that on occasion fifteen-year-old boys who had been convicted of certain offences, including terrorist-related offences, or whose behaviour could not be managed within the open training school system, were sent to Hydebank.[6]

7 At the start of the 1980s the Juvenile Remand Unit, which was previously located in D Wing Annex of Belfast Prison, was transferred to Hydebank. The Juvenile Remand Unit was for fourteen to seventeen-year-olds whose containment in a training school was deemed inappropriate because the court had certified them as unruly or depraved under Section 51 (1) of the Children and Young Persons Act (Northern Ireland) 1968.[7]

8 Hydebank operated in accordance with the Young Offender Centre Rules (Northern Ireland) 1979 which were superseded by the Young Offender Centre Rules (Northern Ireland) 1982.[8] These Rules set out in detail how Young Offenders Centres should operate, including the accommodation that should be provided, how the reception, transfer and discharge of inmates should be handled, and how discipline and control should be applied. Hydebank was managed by a governor, and staffed by prison officers.

4 RGL 1336.
5 HYD 520.
6 RGL 1337.
7 HYD 520.
8 HYD 521-548.

Accommodation

9 Hydebank could accommodate 297 inmates, both sentenced and remand. There were in the region of 14,000 receptions to Hydebank between 1979 and 1995; this figure includes multiple entries of boys who were committed to Hydebank on more than one occasion.[9]

10 The residential accommodation was split across five houses called Elm, Willow, Ash, Beech and Cedar, each of which contained approximately 60 inmates. The Juvenile Remand Unit was located on a third floor landing in Elm House and could accommodate up to twenty boys. It was completely self-contained with its own enclosed exercise yard, so that the boys held on remand did not come into contact with sentenced prisoners.

11 The report of the inspection of Hydebank in December 1983 by HM Chief Inspector of prisons stated that as a Youth Offender Centre, Hydebank was expected to provide, "a brisk regime" with particular emphasis on education and training, both physical and vocational.[10] Therefore, in addition to the residential units, there was a large workshop area for delivery of vocational training courses including joinery, bricklaying, motor mechanics and painting and decorating. A separate education centre provided courses from basic literacy and numeracy up to subjects at Ordinary Level standard. There were also two all-weather and two grass football pitches and a gymnasium with a weight-lifting area attached.[11]

Regime

12 Mr Murray explained that on initial admission to Hydebank, boys would complete a period of induction which was primarily aimed at acclimatising them to their new environment in custody. The procedures included familiarising boys with the daily routine and what was expected of them, and the need to obey rules and conform to routines and procedures was emphasised. After the period of induction, boys would be allocated to one of the other houses on the basis of their attitude, behaviour and length of sentence.[12]

9 HYD 471.
10 HYD 520.
11 HYD 471.
12 HYD 473.

13 During the induction period each boy would have interviews with the governor or his deputy, probation officers, chaplains, staff responsible for education, vocational training and physical education staff. Staff would then compile reports on each boy for consideration at a meeting of the Labour Allocation Board which allocated boys to activities on the basis of their assessed need and time to serve. The Labour Allocation Board was chaired by the deputy governor and attended by heads of departments, including education, vocational training, probation and security.[13]

14 Mr Murray described the daily regime in Hydebank, which commenced at 8.00am when inmates' rooms were unlocked. Inmates were then required to clean their rooms, make their beds and have breakfast. Mr Murray explained that inmates were required to keep their rooms and communal areas clean, make their beds to set standards and maintain their personal hygiene as a means of instilling discipline.[14]

15 Inmates had to be ready to attend work at 9.00am. Work included cleaning duties and participation in working parties as gardeners and labourers.[15] During the morning work period a 15 minute tea break would be provided, and all inmates returned to the residential units at 12.15pm for lunch and lock-up. The inmates were unlocked at 2.00pm and remained at educational and sporting activities until 4.00pm before they returned to the residential units for lock-up at 4.45pm. Evening association was provided with unlock at 5.30pm and inmates enjoyed free association and attended evening education or the gymnasium. Lock-up at night varied across the Centre depending on the agreed regime for the house, but the latest lock-up was around 8.30pm, other than for those with Special Privileges who were allowed a later lock-up.[16]

Discipline and Control

16 The major emphasis in Hydebank was on maintaining security and control and instilling discipline. A staged system of progress towards release was operated by means of movement through the houses to the final stage, which was a pre-release unit for those nearing the end of their sentence.[17] The progression was from the reception/committal unit to

13 HYD 473.
14 HYD 473.
15 HYD 474.
16 HYD 475.
17 HYD 520.

Elm, then onwards to Willow, Cedar, Beech and finally Ash. Each house had a progressively more relaxed regime and privileges such as longer association times. The high point in the progression was 'red band' (trusted orderly) status.[18]

17 Inmates could earn special privileges that allowed them to work out in the community and have free movement across the Hydebank site. They could also earn additional privileges such as reduced supervision, more freedom of association, increased access to the gymnasium and attendance at outside events, depending on security clearance and time remaining in custody.[19]

18 Hydebank was subject to the Young Offender Centre Rules (Northern Ireland) 1979 (YOC Rules). Rule 30 of these Rules (revised as Rule 32 of the YOC Rules (Northern Ireland) 1982) detailed 21 offences an inmate could be charged with if he, for example:

- disobeyed any lawful order or neglected to conform to the rules;
- treated with disrespect any officer or any person visiting the Centre;
- was idle, careless or negligent at work or refused to work;
- used any abusive, insolent, threatening, or other improper language;
- was indecent in language, act or gesture;
- committed any assault.

19 Charges against inmates were heard before the governor. When he decided an inmate was guilty of an offence he could award a range of penalties including:

- a caution;
- loss of remission for a period not exceeding fourteen days;
- loss or postponement of payment for work; and
- confinement to room for a period not exceeding three days.

20 In instances of more serious offences the governor could refer the case to the visiting committee or the Secretary of State on the grounds that the awards available to him were insufficient given the gravity of the offence.[20]

21 The visiting committee was an independent body of people appointed by the Secretary of State to ensure that inmates were being treated in

18 HYD 513.
19 HYD 475.
20 HYD 476-477.

accordance with the YOC Rules. It was given authority to enter a Young Offenders Centre with the object of ensuring it was properly run. Members of the Visiting Committee had free access to any part of Hydebank and could speak to any inmate or officer. Inmates had the right of access to members of the Visiting Committee about any matters. The committee met monthly and carried out visits to parts of the centre on the day of its meetings. Members of the committee also made visits between monthly meetings which meant that Hydebank was visited by a member of the Visiting Committee at least once every fortnight.[21]

22 Mr Murray explained that referrals to the Secretary of State or the Visiting Committee were restricted to cases of violence or serious and repeated offences against discipline which the governor considered required a more severe punishment that he could award. In instances where a case was referred and accepted for hearing by the Secretary of State, or more usually the Visiting Committee, the awards were significantly greater and included:

- loss of remission for a period not exceeding four months;
- loss or postponement of payment in whole or in part for work for a period not exceeding 28 days; and,
- confinement to room for a period not exceeding fourteen days.

If an inmate was found guilty of mutiny or incitement to mutiny or of gross personal violence to an officer, confinement to room could be extended to a period not exceeding 28 days.[22]

23 As well as these formal hearing processes the governor could take more immediate action when he deemed it necessary, including temporarily confining an inmate to a protective room approved for the purpose by the Secretary of State. However, the YOC Rules specified that an inmate should not be confined to such a room as a punishment, and in instances when temporary confinement was used the medical officer had to be informed. The governor could also approve the use of restraints, but with the proviso that they should not be used for longer than necessary, and in no case for longer than twenty-four hours without the written permission of a member of the Visiting Committee.

24 The governor could also award immediate removal from association for 24 hours, after which time he had to seek authority of a member of the

21 HYD 487.
22 HYD 477/8.

Visiting Committee or Secretary of State. As part of this process the inmate would be interviewed, and the governor would have to provide evidence about why removal from association was necessary. If the removal was approved it would be for a period not exceeding fourteen days, and any extension would have to be renewed fortnightly thereafter by the Visiting Committee.[23]

25 Although there was a range of sanctions that could be applied to the inmates in Hydebank, we consider that the application of the YOC Rules for their use and the role and remit of the visiting committee provided important safeguards for the welfare of the young people in the Centre.

Governance

26 The Governor of Hydebank reported to the Director of Prison Operations in the Northern Ireland Office (NIO) and Mr Murray explained he had regular contact with the director during his time, who was Roger Kendrick. Mr Murray explained that Mr Kendrick made frequent visits to Hydebank, and carried out rounds of the establishment to satisfy himself that everything was in order.[24] He also explained that staff working in the NIO treatment of offenders branch were also frequent visitors to Hydebank and would have attended a number of routine meetings, such as the board which allocated work to inmates. We noted that an official from the NIO chaired the meetings that determined whether a boy should be trusted with orderly status.[25]

27 In addition, as part of the arrangement whereby HM Chief Inspector of Prisons for England and Wales (HMCIP) inspected one prison in Northern Ireland each year, Hydebank was inspected by HMCIP in June 1982 and October/November 1994. In the report of the 1982 inspection[26] inspectors made adverse comments about the management structure, the dissemination of instructions and information to staff, staff working excessive overtime and lack of staff training, and, in particular, lack of induction training. The inspectors also made recommendations about necessary improvements to health and safety matters such as the frequency of fire drills. However, their conclusions about the treatment and conditions of the boys were positive, and included:

23 HYD 478/9.
24 HYD 484.
25 HYD 513.
26 HYD 503-520.

> "The staff were concerned and caring, taking an interest in the well-being of the inmates from reception to discharge. Inmates' material needs were well provided for, and the arrangements for visits, the provision of food and medical care were of the highest order."[27]

28 In relation to the physical education provided, the inspectors commented:

> "We were most impressed by the quality of work, the enthusiasm of staff, the excellent provision of facilities and the attention given to the individual needs of inmates and their personal safety".[28]

29 We noted that the inspectors recommended that the NIO should define the term "special cell" and give guidance in its use in contrast to the use of punishment cells and introduce a system for documenting and monitoring the use of mechanical restraints.[29]

30 In the next inspection of Hydebank by HMCIP in 1994 the inspectors recorded that Control and Restraint techniques were used sparingly, staff had been trained to operate as part of a three-person team in order to restrain an inmate, and documentation was completed after every incident involving the use of Control and Restraint.[30]

31 The inspectors were impressed by the quality of care provided in Hydebank. They commented:

> "Although staffing levels were high the quality of supervision and standard of work achieved by most officers justified these levels. Landing officers (known as class officers) had excellent relationships with inmates whom they clearly knew well. The safety of inmates was protected by the alertness of staff."[31]

32 They reported that they found a general absence of bullying and recorded that inmates had told them they felt safe.[32] They were concerned to find that house staff were able to award their own unofficial sanctions for small infringements, and recommended that sanctions should only be awarded after an accusation had been properly investigated by a senior member of staff.[33]

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27 HYD 509.
28 HYD 513.
29 HYD 511.
30 HYD 1619.
31 HYD 1610.
32 HYD 1612.
33 HYD 1617.

33 Inspectors found that there had been 256 adjudications carried out by the deputy governor in the first ten months of 1994. When guilt was proven, sanctions were severe, but in the cases they examined the sentences appeared appropriate to the offence.[34]

34 We particularly noted the concern recorded by the inspectors that seven juveniles (five fifteen-year-olds and two sixteen-year-olds) had been sent to Hydebank for five week assessment periods as a result of unruly behaviour.[35] The inspectors commented that they found no evidence that these boys were undergoing assessment. They were particularly concerned that the two sixteen-year-olds had neither been charged before a court, nor convicted of a criminal offence and were clear in their view that they should not have been held in a penal institution.[36] Consequently the Chief Inspector recommended to the Secretary of State that Schedule 5, 10(1) of the Children and Young Persons Act (Northern Ireland) 1968, should be reconsidered so as to avoid imprisoning juveniles who had not been charged with a criminal offence. [37]The DoJ confirmed that this recommendation was addressed through a programme focused upon reviewing and modernising children's services across various aspects of the juvenile justice system that the NIO was already engaged in at the time it received the Chief Inspector's recommendation.[38]

35 Mr Murray told us that members of the International Committee of the Red Cross also visited Hydebank and reported the conditions they found to HM Government.[39]

36 Any complaints or criticisms made by inmates to the members of the Visiting Committee were reported to the governor. More serious complaints could be reported to the NIO. The Visiting Committee submitted an annual report to the Secretary of State detailing their visits to the Centre and any matters arising. We found that the policy and framework for dealing with complaints in Millisle were undermined by the way they were implemented in practice. We did not hear evidence about similar problems in relation to the handling of complaints in Hydebank.

34 HYD 1617.
35 HYD 1650.
36 HYD 1651.
37 HYD 1653.
38 HYD 3123.
39 HYD 487.

37 Each year the governor had to provide an annual report to the Secretary of State which covered the inmate population, the behaviour of inmates, security and staffing issues. The annual report included a number of appendices including a report from the chairman of the visiting committee about the committee's work and its conclusions and recommendations for the year. In the annual report for 1984 the chairman of the visiting committee commented:

> "The past year has seen the YOC maintaining its image of a progressive and rehabilitative establishment."[40]

Evidence from Witnesses about Hydebank

38 We received evidence from four witnesses about their stays in Hydebank, which occurred between 1983 and 1990. Mr Murray told us he did not know any of these witnesses, and that given the dates they were in Hydebank he does not believe any of them were present when he worked in the centre. The information provided by the DoJ shows that HIA 253 was remanded to Hydebank on 16 May 1984 and received a 12 month sentence to Hydebank on 24 July 1984.[41] He was discharged from Hydebank in January 1985.[42] Mr Murray commenced work in Hydebank on 29 October 1984 so there was a brief period of approximately two to three months when Mr Murray was working in Hydebank and HIA 253 was an inmate there. We accept that Mr Murray does not remember HIA 253 given the briefness of the overlap and that it occurred when Mr Murray had just commenced his employment in Hydebank.

39 Mr Murray provided helpful general responses to the allegations of witnesses on the basis of his experience of working in Hydebank and his knowledge of some of the staff that are referred to in the statements of witnesses.

Physical Punishment

40 HIA 373 had four stays in Hydebank but only the first of these, which was for two weeks from 28 October 1983 to 11 November 1983, and the second, which was for six weeks between 11 January 1984 and 24 February 1984, are within our Terms of Reference, as HIA 373 was over 18 when he spent his final two periods in Hydebank.

40 HYD 11931.
41 HYD 048.
42 HYD 027.

41 HIA 373 told us that a member of staff HB 4 who worked in reception and another staff member slapped him for not addressing them as "Sir".[43] HB 4 proved a statement to the Inquiry in which he stated that he had no recollection of HIA 373 and denied slapping him or any boy. He stated:

> "I had an authoritative voice and I would have shouted if necessary to keep order, but I never needed to slap anyone."[44]

Mr Murray who worked with HB 4 commented that HIA 373's allegations about HB 4 were at odds with his knowledge of the officer whom he found to be "a professional, committed, dedicated officer".[45]

42 HIA 373 told us that when he refused to co-operate with the reception process at the start of his second stay in Hydebank he was stripped of his clothes, and when he tried to hold on to his underpants a female RUC officer who had escorted him to Hydebank insisted they were removed and kicked him in the stomach.[46] He also described being slapped around the face daily by HB 5, who was in charge of Willow House, for such things as not cleaning his room properly.[47] He told us that he observed other inmates being physically abused by officers and receiving no medical treatment for injuries they sustained. He described inmates barricading themselves in their cells and being beaten by officers for doing so. He said that following one such incident he saw a boy being dragged down three flights of stone steps, his head hit off each of the steps, and he heard later that the boy was so badly bruised that he was kept hidden in the punishment unit until his injuries healed.[48]

43 Mr Murray said he had no knowledge of officers routinely slapping inmates and that any officer found assaulting or misusing force against an inmate would be subject to disciplinary processes and could lose his job as a result.[49] He stated that he had no recollection of routine serious incidents or cell barricades, and pointed out that that it would have been impossible for an inmate to be kept hidden in the punishment unit, as it was clearly visible to managers in Hydebank and members of the Visiting Committee had regular access to it.[50] When Mr Murray gave evidence in person he

43 HYD 009.
44 HIA 2870.
45 HYD 490.
46 HYD 012.
47 HYD 009.
48 HYD 011.
49 HYD 491.
50 HYD 492.

emphasised that members of the Visiting Committee were not accompanied by staff during their visits and that they valued the independent nature of their role. He explained that as the deputy governor and then governor of Hydebank he had to attend meetings with the Visiting Committee to address any matters of concern or issues arising from their visits.[51]

44 When HIA 253 was admitted to Hydebank, he saw it as being given "short sharp shock treatment",[52] to ensure he followed the rules. He told us that officers knew what pressure points to use to control the behaviour of inmates, and said that when they touched pressure points on his shoulders he fell to his knees.[53] When he gave evidence in person he posed the question about whether there was Government approval for the use of such techniques.[54] Mr Murray said in response that he had no knowledge of staff bringing boys to their knees by pressing pressure points. He explained that up until the mid-1980s officers received use of force training based on judo techniques, which included using arm holds to take a prisoner who was being violent to the ground, but that from the mid-1980s onwards training on Control and Restraint techniques was introduced. He explained that these techniques placed an emphasis on de-escalation and the use of minimum force if other measures to get a situation under control had not proved successful.[55]

45 David Dowds submitted a statement on behalf of the Northern Ireland Prison Service about the use of Control and Restraint techniques in Hydebank. He provided contemporaneous documentation to show that the policy was that force should only be used when necessary and no more force than is necessary should be used. He referred to guidelines issued in August 1988 about the use of force in the prison service. This pointed out to officers that the use of force when it was not necessary, or the use of more force than was necessary to achieve the objective, was both a criminal offence and a civil wrong.[56] He also provided exhibits showing how the policy was disseminated to staff, how training was provided to staff and recorded, and how the use of restraint was monitored by the prison service.

51 Day 159, p.155.
52 HYD 027.
53 HYD 027.
54 Day 142, p.27.
55 HYD 480.
56 HYD 1676.

46 Mr Murray accepted that he did receive and deal with complaints about officers physically abusing inmates. He explained that such complaints were formally investigated with, where necessary, the involvement of the RUC. He provided an example where he continued an investigation into alleged mistreatment despite the fact that the inmate in question withdrew his complaint.[57] He also indicated when he gave evidence in person that the young people who were inmates in Hydebank would not have tolerated the type of systemic physical abuse described by some witnesses, and that it would have led to major riots.[58]

47 We accept that some officers in Hydebank may have taken an overly physical approach to establishing their authority and maintaining discipline, and would have dealt swiftly and robustly with any behaviour they viewed as insubordination. However, we consider that the approach of senior managers as described by Mr Murray and the active oversight of the Visiting Committee would have provided some protection from such behaviour. We have given careful consideration to the allegations we received about physical abuse in Hydebank but we do not find that they were sufficient to amount to evidence of systemic physical abuse of inmates.

Sexual Abuse

48 We received only one allegation of sexual abuse in Hydebank. HIA 373 told us that he was not sexually abused in Hydebank and did not observe such abuse.[59] However, he told us that he knew of boys who had been sexually abused in the centre including a friend of his HB 9, who had told him that he had been sexually abused by a senior prison officer, HB 10. HIA 373 indicated that HB 10 was connected to a paedophile network based in Coleraine and that HB 9 was abused by members of that ring following his release from Hydebank and that this combined abuse was the reason HB 9 took his own life four or five years ago.[60]

49 Mr Murray said he remembered an officer called HB 10 but did not recall any complaints against him. He told us that he received no allegations of sexual assaults while he was in Hydebank and confirmed that if he had he would have reported them to the police.[61]

57 HYD 496/7.
58 Day 159, p.136.
59 HYD 014.
60 HYD 013.
61 HYD 493.

50 Given this is the only allegation of sexual abuse we received and it is not an account from a witness that personally suffered abuse, we do not find evidence of systemic sexual abuse in Hydebank.

Emotional Abuse

51 When HIA 253 gave evidence in person he recounted an incident when prison officers suspected he had been masturbating in his cell during a lock-up period and gave him a "couple of slaps" for doing so. He described how when the doors were unlocked one of the officers grabbed him by the ear and marched him up and down the corridor in front of other inmates and made him tell them that he had been masturbating. He indicated that it was being paraded in front of other inmates that he found particularly humiliating.

52 While we recognise how distressing such treatment would have been to HIA 253 we do not consider that this single incident amounts to systemic abuse.

Unacceptable Practices

Excessive Chores

53 HIA 373 said that the regime in Hydebank was "designed to break your spirit". He described how if his room were not cleaned or his bed not made to the required standard they would be wrecked by officers and he would have to start again.[62] HIA 253 also described beds being wrecked by officers if they were not made properly[63] and recalled being made to clean the floor of his cell with a tooth brush.[64]

54 In contrast, although HIA 138, who was in Hydebank in 1990, described the regime as akin to a boot camp, he said staff treated everyone the same and that he did not receive any physical punishment.[65]

55 Mr Murray confirmed that cell inspections were routine but said he never witnessed cells being wrecked.[66] He also confirmed that inmates on committal were expected to carry out menial tasks, which included a lot of cleaning, but said this was to establish a routine and encourage a work ethic.[67] While he accepted that the committal regime required inmates

62 HYD 010.
63 Day 142, p.28.
64 HYD 027.
65 HYD 021.
66 HYD 491.
67 HYD 491.

to conform,[68] and that there was a strong emphasis on discipline and control,[69] he did not accept that the regime was designed to break the spirit of any inmate. [70]

56 It is clear that the committal regime was designed to ensure compliance and conformity. There can be a narrow dividing line between insistence on routines and the achievement of exacting standards and excessive chores and a requirement for perfection that amounts to abuse. We consider that officers may have crossed that line on occasion in Hydebank but the evidence we have heard about isolated incidents is not sufficient to amount to a finding of systemic abuse.

Sectarianism

57 HIA 373 said that prison officers singled out boys from a Catholic or nationalist background, gave them a particularly hard time, and were open about their admiration for, and loyalty to, loyalist paramilitaries.[71] He also recalled an officer with the nick name "Paddywhack" boasting that he was a former member of the Parachute Regiment and was on duty on Bloody Sunday. Mr Murray stated that he had no memory of an officer with the nick name "Paddywhack",[72] and confirmed that when he was in Hydebank he received no reports of sectarian behaviour between inmates or between inmates and staff.[73]

58 We have carefully considered the evidence we received about unacceptable practices, and while we accept that witnesses were unhappy about the practices they described we do not consider that their accounts amount to evidence of systemic abuse.

Neglect

Food

59 HIA 434 told us that the food was insufficient and of poor quality[74] and HIA 373 said that it was not particularly nutritious.[75] DoJ pointed to the

68 HYD 491.
69 HYD 474.
70 HYD 491.
71 HYD 013.
72 HYD 494.
73 HYD 493
74 HYD 034.
75 Day 156, p.56.

assessment of HM Inspectors of Prisons as recorded in the report of their 1982 inspection of Hydebank that the catering was good, with varied menus, and was consistently well-prepared and wholesome food.[76]

60 Mr Murray said in his statement that the Northern Ireland Prison Service was very aware of the need to ensure that inmates had sufficient to eat. He explained this further when he gave evidence in person by telling us:

> "There are two things prisoners value. One is his visits – the other is his food. Mess around with any of those and you're going to have problems."[77]

Medical Care

61 HIA 373 said he was not allowed privacy when seeing the doctor, that officers who attended with him made comments and humiliated him, and neither the doctor nor the nurse intervened to stop them.[78] Mr Murray stated that officers would not have been routinely present during medical examinations, and would only have been in attendance if there were concerns about a boy's behaviour.[79]

62 HIA 434 recalled being made to shave every day and his skin became very sore as he was not yet ready to shave. He explained that this practice only stopped when he saw the doctor in Hydebank, who gave him cream for his skin and said he should only be required to shave every second day. HIA 434 said that he continued to get cuts and sores from shaving even when it was limited to every second day.[80] Mr Murray stated that boys normally shaved prior to unlock, and that it would be unlikely that staff would have known whether an inmate had shaved or not if they had no need to shave.[81] The DoJ commented that this incident as described by HIA 434 shows that the regime in Hydebank was sufficiently flexible to take into account medical conditions.[82]

Clothing

63 HIA 373 described being embarrassed about being made to wear standard issue clothes when he was admitted to Hydebank[83] and HIA 253 also

76 HYD 510.
77 Day 159, p.129.
78 HYD 012.
79 HYD 492.
80 HYD 034.
81 HYD 495.
82 RGL 90194.
83 HYD 09.

described having to wear such clothes and said that they were used to make new inmates stand out and embarrass them.[84] The DoJ pointed out in its closing submission to this module that in 1982, prior to HIA 373's and HIA 253's committal to Hydebank, the agreed policy was:

> "all prisoners will be permitted to wear their own clothing at all times... Prisoners who are either unwilling or unable to provide clothing for their own use will be provided with official - issue clothing."[85]

The DoJ also pointed out that the report of the HMCIP inspection of Hydebank in June 1982 recorded that clothing issued to inmates was "sweaters and jeans, which were popular, serviceable and well cared for."[86]

Education

64 HIA 373 complained about the lack of educational support he received in Hydebank and that in particular there was no focus on rehabilitation or preparing young men for a life without re-offending. He was scathing about the quality of the social skills training he received, including the advice given about the transmission of AIDS. HIA 253 said that he attended a mechanics class in Hydebank, and although he learnt some aspects he did not receive a full training in the basics of mechanics. He indicated that the officer in charge of the class got him and other inmates to help make canoes, which he then sold, rather than teaching them about mechanics.

65 These accounts are at odds with HMCIP inspectors' assessment of the education facilities in Hydebank. They found teaching was geared to meet the individual needs of inmates and took account of the fact that some inmates were not ready for vocational training or their sentences were too short for them to complete assessed training. They were particularly impressed with the social skills course, and commented that the pre-release course and the alcohol awareness courses, which were voluntary, were oversubscribed. Inspectors went as far as to suggest that the approach to social skills training in Hydebank could be advantageous for young offender centres in England and Wales.[87] When he gave evidence in person, Mr Murray also referred to the effectiveness of the social skills training and the education provision in general provided in Hydebank.

84 Day 142, p.30.
85 HYD 1465.
86 HYD 11201.
87 HYD 13704.

66 While we recognise and accept that witnesses were unhappy about aspects of the care they received in these areas we do not consider that their complaints amount to evidence of systemic neglect.

Conclusions

67 We accept that on admission to Hydebank boys experienced a strict regime, and that the repetitive cleaning tasks and requirement to maintain their cells to a strict high standard were aimed at ensuring inmates conformed to the discipline of Hydebank and the authority of officers. We also think it is probable that some officers took the approach of intimidating boys at the committal stage in order to enforce obedience and discourage any resistance to the regime.

68 However, we recognise that Hydebank was a prison and was dealing with some boys who had been found unmanageable in open training schools, and a firm approach was necessary in order to maintain discipline. Despite that imperative, the evidence of Mr Murray and that provided through inspection reports and reports of the visiting committee indicate that a progressive regime was operated that allowed boys to gain privileges and to move purposefully towards release. That evidence also indicates that there was a range of educational, vocational and training activities available to the inmates.

69 We accept that the witnesses we heard from had negative experiences in Hydebank and do not consider their time there in a positive light. However, having carefully considered the evidence provided to us, we have decided that the complaints we received do not amount to evidence of systemic abuse in Hydebank.

Chapter 17:

Module 10 – Millisle Borstal

Introduction

1 Woburn House, as it was officially known, was a borstal for males aged sixteen to twenty-one from 1956 to 1980, but it was usually known as Millisle Borstal. It was designed to provide training for work, education and leisure activities for young offenders who were unsuited to training schools and who would otherwise have been sent to prison.

2 The Inquiry addressed the allegations of ten applicants in Module 10, which commenced with an introduction by Junior Counsel on 18 January 2016. Seven applicants were heard in person and two statements were read out on the grounds of the ill-health of the applicants, HIA 262 and HIA 320. The statement of one further witness, HIA 294, was based on the account he gave to the Acknowledgement Forum, as he had hoped to give evidence in person but was sadly deceased before he was able to prepare a witness statement. Evidence was heard from three former officers and one former governor (Duncan McLaughlan), as well as Stephen Davis on behalf of the Department of Justice. Evidence for the Module was completed on 26 January 2016.

3 We wish to express our appreciation for the help provided by the witnesses concerning their experiences as trainees at Millisle, nearly all of whom had already given evidence in relation to other residential institutions. We are aware that recalling such memories can be a painful process. We are grateful to all those in the Department of Justice who identified relevant records and contributed to the statements for the Inquiry presented by Stephen Davis, the Director of Operations for the Northern Ireland Prison Service (NIPS). We are indebted to the officers who were employed at Millisle for providing first-hand recollections, and in particular to Duncan McLaughlan who was Governor during the period covered by most of the allegations.

4 Nearly all the evidence was provided by the Department of Justice, but some records, such as Prison Service personnel details, were not available, presumably as a result of destruction of files considered to be no longer required. In particular, there was a review of records at Millisle in May 1977 at which it was noted that there were 'dead' files for over a thousand trainees and these were presumably destroyed.[1] There are therefore some gaps in our knowledge. Unlike other institutions investigated by the Inquiry there were no social services files concerning the trainees during their time

1 MIL 141, 143.

in Millisle as there were no social workers actively involved with them then. There was also very little police documentation, as (with one exception) the witnesses had not complained to the police and their allegations had not been investigated previously.[2]

The Premises

5 Woburn House was a stately home on the outskirts of the village of Millisle, three miles south of Donaghadee in the Ards peninsula in County Down, with views across the North Channel. The property was separated from the sea only by the main road, the A2. The house was rebuilt by George Dunbar MP as an Italianate mansion in the 1860s, and it was acquired by the state in lieu of death duties in 1952.[3] The Ministry of Home Affairs decided to use the premises as a borstal because the buildings were sufficient to house the trainees and there were 56 acres of grounds, largely woodland but with space for sports facilities and further developments.[4] Although not very far from Belfast if one had a vehicle, it was difficult to reach for those who were reliant on public transport, and this reduced visiting by trainees' families.[5]

6 The main house had a grand facade, painted white, facing the road and the sea. The ground floor was used for reception, administrative offices, a small rest room for staff to have snacks, two common rooms for the trainees, the dining room, the kitchen and the laundry. The first floor housed the dormitories, mostly for four or five boys in each room, and a medical room was sited between two of the dormitories.[6] The seamstress's room was in the attic, which was mainly disused.[7]

7 Behind the main building there was a variety of outbuildings which housed the workshops and cells used to isolate trainees at times of crisis, though their use was discontinued when Duncan McLaughlan took over as Governor in 1975. There was also a room which was available for 'special grade' trainees to use, where they had a greater degree of freedom.[8] Beyond these buildings there was a walled garden and greenhouses used for horticultural training.

2 MIL 106-107.
3 MIL 109.
4 For a plan of the site, see MIL 28129.
5 Day 180, p.32.
6 Day 182, p.23.
7 Day 182, p.26.
8 Day 182, pp.44.

8 To the right of the main building, when viewed from the main road, there was a substantial building housing the gymnasium, classrooms and more workshops. To the extreme right there was the Governor's house. The ground rose landwards throughout the site, which was encompassed by a wood that was termed 'the forest'. The main house and buildings described above were used for the open borstal. There was no fencing and the front door was managed by a 'special grade' trainee who held the key.[9] [10]

9 To the left of the main house, adjacent to the main road, there were 26 units of staff housing, mainly in the form of semi-detached houses. Behind them was the closed borstal, which was on the site of a farm acquired in 1970 and demolished to make way for the new development. The closed borstal was opened in 1977 and was a separate purpose-built unit, also within sight of the sea, although further inland. It was surrounded by a security fence and admission was regulated. It was self-contained and had all the facilities required for a closed section except that the laundry, the kitchen and some other services sited in the main building provided for both the open and the closed units.[11]

10 The closed borstal at Millisle was a two-storey building with a central section and two wings leading from it. In the centre there were administration offices, a visiting area, interview rooms, a recreational room, medical unit, reception unit, punishment cells, games hall, library, TV rooms, billiards room, quiet room and two workshops.[12] In the wings there was sleeping accommodation made up of 33 single rooms, twelve twin rooms and two dormitories, each with nine beds; in total this amounted to 75 places, but with the use of bunk beds this could be exceeded.[13] The ground floor was used for the allocation and assessment unit and for the segregation unit. Upstairs, one wing was used for trainees who had been assessed and were awaiting a move to the open section. The other wing was for trainees for whom an open unit placement was deemed unsuitable. The buildings were surrounded by a 17' high weldmesh fence.[14] There was also a small church for the use of all denominations within the fence so that there was no need for trainees from the closed unit to leave the site for religious observance.[15]

9 MIL 710.
10 Day 182, pp.34.
11 Day 182, p.19.
12 MIL 165-166, 173-174.
13 MIL 164, 172.
14 MIL 165.
15 MIL 171.

The Borstal System

11 The roots of this type of provision go back to 1895 when the Westminster Departmental Committee on Prisons, known as the Gladstone Committee after its chairman, Herbert Gladstone, recommended the creation of a type of special institution for young offenders which would be:

> "a half way house between the prison and the reformatory. It should be situated in the country with ample space for agricultural and land reclamation work. It would have penal and coercive sides which could be applied according to the merits of the particular cases. But it should be amply provided with a staff capable of giving sound education, training the inmates in various kinds of industrial work, and qualified generally to exercise the best and healthiest kind of moral influence."[16]

12 The original model for this type of institution was established in 1902 in the village of Borstal in Kent, England, and it was also piloted in Ireland in 1906. Authorisation for a system of borstals was provided by the Prevention of Crime Act 1908, which applied to the whole of Great Britain and Ireland.[17]

13 When partition took place in 1921 there was no borstal in Northern Ireland, and a third of the trainees in Clonmel Borstal were from Belfast. For the first few years boys requiring borstal training were first placed at Feltham Borstal near London and then, as the distance was found to render Feltham unsuitable, at Greenock in Scotland. A total of more than 60 boys were sent to England and Scotland in this way.[18]

14 However, the new Government of Northern Ireland addressed the problem speedily. A report was prepared in 1923 by the Departmental Committee on Reformatory and Industrial Schools in Northern Ireland, known as the Moles Committee, and it addressed the question of borstals.[19] The Committee concluded that a male borstal should be set up in Northern Ireland, but that the number of females requiring that type of provision was insufficient to warrant the establishment of a borstal for them.

16 Quoted in Niall Osborough *Borstal in Ireland: Custodial provision for the young adult offender 1906-1974* (1975), p.3.
17 MIL 10013-10026.
18 MIL 108.
19 *Report of the Departmental Committee on Reformatory and Industrial Schools in Northern Ireland* (1923) HMSO pp. 22-27: (MIL 10159-10164).

15 The outcome was the passing of the Malone Training School Act (Northern Ireland) 1926. Malone School had been run as a reformatory by a voluntary board, and then by Belfast Corporation, but in 1926 it was taken over and fully funded by the Government. It housed both a reformatory and a semi-secure borstal, which functioned separately on the same site and under the same governor until 1956. Malone Borstal was then discontinued under the Malone and Whiteabbey Training Schools Act (Northern Ireland) 1956 and on 27 July 1956 the borstal was moved to Millisle, which was an open borstal, set up under Sections 1 and 2 of the Prison Act (Northern Ireland) 1953.[20] For some time there was a single governor for both Malone Training School and Millisle Borstal, and a housemaster (the equivalent of an assistant governor) was resident in charge of the borstal.[21]

16 The borstal system was expanded further by the introduction of a closed borstal at Armagh Prison in 1963, and from that point trainees spent the first months of their sentences in closed conditions at Armagh before moving to Millisle. Meanwhile Malone continued as a training school until a new purpose-built school was opened at Rathgael.[22]

17 The provision at Millisle was enhanced with the addition of new vocational training workshops and two new classrooms in 1966, residential staff accommodation in 1968, and a gymnasium in 1970.[23] These developments were funded by the Ministry of Home Affairs.

18 Throughout the 1970s considerable pressure was put on the borstal service by the Troubles and by the consequent need to accommodate boys and young men who had been involved in civil disturbance and offending. Millisle only suffered one serious disturbance during the Troubles. On 15 May 1972 a group of 35 trainees obtained access to the roof from the dormitory in Alexander House, and they caused considerable damage to the roof, the dormitory and the medical suite. Only one absconded and the others gave themselves up when the army and the police arrived in force. The rioters were all transferred to a secure unit in Magilligan Prison and work commenced to make the damage good the next day.[24]

20 MIL 110, 148.
21 MIL 111.
22 MIL 109, 10699-10713.
23 MIL 110.
24 MIL 24253.

19 Woburn House open borstal could accommodate 75 trainees, with some flexibility to increase. The average daily borstal population in Northern Ireland (which at first included the trainees in Armagh Prison) rose steadily from 84 in 1972 to 145 in 1979.[25]

20 In 1970 a farmhouse together with 33.5 acres of farm land adjacent to Woburn House was acquired with a view to creating a closed borstal. Demolition of the farm buildings began in 1974[26] but the first trainees were not admitted until November 1977[27], a year later than planned,[28] and by this time young offenders had had to be housed in closed borstal units at the Maze, Crumlin Road Jail and Magilligan Prison. With the opening of Millisle these borstals were now closed.[29] The closed section was designed to hold a further 75 trainees, but could take more with doubling up. Millisle was therefore capable of catering for a total of 150 trainees, or more if pressed.[30]

21 As the Governor of both the open and closed sections, Duncan McLaughlan issued a notice to staff:

> "First, it is important that all staff at all levels view the two institutions as one institution. There is one management, one staff and one task, which is to provide borstal training in the best and most humane manner possible".[31]

In the event, there was a unified management, but the two staff teams remained largely distinct unless there was a need for help because of staff shortage, and the modes of working of the two sections were quite different, despite having the same aims.[32]

22 Millisle itself only functioned with the two sections for three years and it was also closed in 1980 with the introduction of the Youth Offender Centre (YOC) system under the Treatment of Offenders (Northern Ireland) Order 1980, as the borstal sentence had become redundant.[33] The indeterminate nature of the borstal sentence was unpopular with inmates, whereas the YOC sentence was determinate. The closed borstal was shut

25 MIL 117.
26 MIL 24298.
27 MIL 27750.
28 MIL 24765.
29 MIL 725.
30 MIL 710.
31 MIL 162.
32 Day 182, p.99.
33 MIL 115.

on 30 September 1980. On the last day, Duncan McLaughlan noted in the governor's journal:

> "We have shown that both trainees and staff can experience meaningful relationships. The heavy hand has not been needed."[34]

23 For a few months Millisle open section was technically a YOC, but it also closed on 31 December 1980 when the last trainees were transferred to Hydebank.[35] In his last entry in the governor's journal, Duncan McLaughlan wrote:

> "...whilst I welcome the closure of a penal establishment it is a matter of deep regret that Northern Ireland no longer has an open institution. There is no doubt in my mind that we at Millisle have shown what can be achieved when one attempts to establish a humane regime that treats both staff and inmates as human beings. We have not set out to rehabilitate inmates, as such an aim is based on myth and wishful thinking; we have tried to show that imprisonment need not be a totally negative experience."[36]

24 Thereafter the closed borstal premises were used for Lisnevin Training School, and the open section became a training centre for the Northern Ireland Prison Service.[37]

Open and Closed Borstals

25 There were two types of borstal: closed and open. Both were part of the Prison Service and most of the staff in both types of borstal were prison officers. The practice was for boys to be admitted to a closed borstal,and when they had demonstrated that they had settled down, typically after about two or three months, they were moved on to the open borstal. The closed borstals were more army-like and regimented, with uniforms, an emphasis on parades and chores, and a tough regime in which conformity was demanded. Officers had to be addressed as 'Sir'.[38] By contrast, in the open borstals boys wore a choice of clothing and were treated more liberally, with more freedom of movement, additional rewards and less regimentation.

34 MIL 185.
35 MIL 202.
36 MIL 157.
37 MIL 111-112.
38 MIL 055.

26 In 1965, for example, Governor Vogan issued instructions to trainees:

> "You must march to and from work in a quiet smart and orderly manner."[39]

By Duncan McLaughlan's time, twelve years later, trainees in the closed section "walked in a fairly orderly fashion", but this was not required of those in the open section.[40] MZ 1, who was used to working in prisons, was amazed to find that boys delivered newspapers to staff houses, and that one officer took 30 trainees for a walk in the surrounding countryside and was not clear about the numbers checking back in on their return.[41]

27 Because of the contrast in the regimes, trainees were usually keen to move on from the closed borstal to the open section as quickly as possible. In oral evidence Duncan McLaughlan said that canny trainees displayed difficult behaviour on arrival in the closed section and then became more conforming, to demonstrate that they had learnt their lesson and were ready for transfer, whereas less intelligent boys did not play the game and spent longer in the closed section.[42]

28 For most of its existence Millisle was an open borstal and (although some measures were taken to reduce absconding, such as bars on certain windows) reliance was placed upon trainees to complete their sentences without the use of security measures to prevent absconding. Trainees who had achieved a level of trust were given the freedom of the grounds. There was, however, always the possibility that problem behaviour in the open borstal, such as absconding, could lead to a return to the closed borstal.

The Applicants

29 Boys were admitted to borstal for a number of reasons: predominantly they had records of offending, they had absconded frequently from training schools, or they were proving difficult to control in other settings such as children's homes. Of the ten applicants to the Inquiry who were trainees at Millisle only two had not been in a training school prior to admission. One of these had been in three children's homes, and only one had no record of residential care prior to committal to Millisle.

39 Governor J. W.Vogan General Instructions to Borstal Trainees (1 December 1965) Instruction 7: his emphasis. (MIL 615-616).
40 Day 182, p. 35.
41 Day 181, p.32.
42 Day 182, p.51.

30 Because of their histories in other residential childcare institutions, the trainees therefore had the potential for presenting the staff of Millisle with severe handling problems, but the borstal model offered the boys more positive opportunities than prison life, and the hope was that they would seize the opportunities and avoid a life of offending and prison sentences. Nonetheless there was a clear expectation that the staff would be in control and prevent further offending by containing the boys, only offering them greater freedom as they responded to the training programme. A small percentage who did not respond were moved on to a prison.

31 Millisle opened in 1956 but there were no applicants applied to the Inquiry who were there in the 1950s, and only one in the 1960s. Three who were resident in the mid-1970s made allegations only against one particular officer, Officer Skillen. Although the closed borstal at Millisle was only open from 1977 to 1980, six of the ten applicants were admitted to Millisle closed unit before moving on to the open borstal, and while many of their complaints concerned Officer Skillen, the remainder related largely to their treatment in the closed section.

32 For the purposes of this chapter, therefore, the evidence has been drawn together to follow trainees through from their initial admission to the closed borstal to their transfer to the open borstal and then on to their discharge. The allegations of abuse which they made follow.

The Closed Borstal

33 The remit of the closed section was:

> "(i) to receive all young men sentenced to Borstal Training after their initial period of twenty-four hours in HMP Belfast [for registration].
>
> (ii) to assess trainees for their suitability for training in open or closed conditions.
>
> (iii) to provide a full programme of training for those trainees whom it is felt appropriate to place in open conditions.
>
> (iv) to provide a particular programme for those trainees who have rejected the training regime in the open or closed sections."

It was intended to keep the newly admitted trainees who were there for assessment away from those in the segregation unit.[43]

43 MIL 166.

34 The task of the unit was:

> "(i) to introduce trainees to Borstal Training and its implications for them.
>
> (ii) to assess the trainees' need for open or closed conditions.
>
> (iii) to prepare a training plan that the trainee will follow during his training period".

An Allocation Board made up of the senior officers of the borstal decided on the training plans and the units to which the trainees would go. It was intended that the regime in the assessment unit should be "vigorous".[44] Many of the allegations of physical abuse relate to time spent in the assessment unit.

35 Trainees in the segregation unit consisted of:

(a) a small number where movement to the open section was deemed inappropriate, possibly because of the nature of their offences;

(b) some who had failed in the open unit but who, it was hoped, would return there shortly through experiencing an "austere" regime;[45] and

(c) those who had failed in the open section but were to complete their sentence in the closed section.[46]

36 Several witnesses gave graphic accounts of gratuitous physical attacks which they sustained on the day of their admission, presumably intended to indicate to newcomers who was in charge. If trainees did not indicate that they submitted, for example if they complained about their ill-treatment, this was followed up by further punishment until they had been worn down. They described the atmosphere in the closed borstal as being regimented and intentionally punitive, presumably with a view to achieving the obedience of the trainees.

37 HIA 162 said that "Everyone is beaten on their first day there."[47] HIA 294 said that he was sent to Millisle for discipline, aged about seventeen:

> "So I went there for this discipline and as soon as I went through the door I got beat in there, kicked in the shins and there used to be the old brogues they all wore in them days."[48]

44 MIL 167.
45 MIL 169.
46 MIL 712.
47 MIL 044.
48 MIL 064, 30077.

38 HIA 416, who had no previous experience of institutional life, wrote:

> "I was brought into the canteen which was full at the time when I arrived. I was told that I had five minutes to eat. I had not eaten all day as I was in the Court house, and an Officer asked if anyone wanted more bread. I put my hand up and he told me to get the fuck out of there. He then took me into the corridor and battered me. I was then brought to a cell. That night was the worst night of my life as I did not know what was going to happen to me the next day."

39 "The next morning I was given black boots, a black jacket made of cloth and trousers. I had my hair shaved. An officer told me that I didn't have a mother or a father and that the officers in charge were my parents now. He then said that I was only a number. My number was 479 and he told me that they had me for three years. He then slapped me. I had just turned sixteen years of age."[49]

Three years was the maximum without remission. As it happened, HIA 416 remained in Millisle for almost exactly a year, but because of the isolation of the borstal he was visited by his family on only three or four occasions until his discharge, when his father collected him.[50]

40 HIA 320 said that he was assaulted by an officer, LN 18, in the assessment centre and he started screaming, which caused other staff, including Governor McCutcheon, to come in to see what was happening.[51] LN 18 strongly denied the allegation, as he could not place trainees in the punishment block without instructions from the governor.

41 HIA 320 added that in consequence of the incident concerning his admission, some officers, such as LN 20, made things difficult for him, slapped him and put him in the punishment block, but the governor was on his side and he was also supported by a kind officer (Mr McDowell).[52] LN 20 stated that he had no recollection of HIA 320, but that he never used force and did not have the authority to send a trainee to the punishment block.[53]

42 On arrival, trainees were subject to assessment during their first few weeks in the closed section. HIA 416 wrote:

49 MIL 070.
50 MIL 072, 075.
51 MIL 061.
52 MIL 061.
53 MIL 829-830.

> "I had to do six weeks in the first wing that I was placed in. It was called the assessment wing. I had to learn how to make my bed pack which consisted of a blanket then a sheet [and then another blanket]. It was the way that the Army had to make beds. The staff would come in and measure the beds to make sure they were made right. Your comb and toothbrush had to be a certain distance away from each other, the right side up and facing each other."[54]

43 > "The staff would come in and inspect our rooms. We had to shine our boots so that we could see our faces in them. If they checked your cell and found any dust on their finger tips they would wreck the whole bed and you would have to tidy it all. I cleaned my cell and the Officers would still find dust. ...I would then have to clean the whole cell again. ...In the room there was a chair and a Bible. We were not allowed to sit on the chair."[55]

Other witnesses confirm this picture. The cleaning of the cells clearly went well beyond what was required to run an institution hygienically, and it was part of the conditioning process to ensure that trainees conformed.

44 HIA 248 said of the closed unit:

> "The regime there was very tough and you needed permission from the staff to do everything."[56]

HIA 262 said:

> "It was run like an army recruitment camp. We wore uniforms, marched and stood to attention".[57]

This was required of trainees whenever an officer passed them according to HIA 416.[58] HIA 162 said:

> "It was extremely regimented in Borstal and there were rules for everything. If I did not follow the rules to the letter then I would be beaten by staff. The prison officers were tough and were always looking for faults in what I was doing or the state of my cell. If there was a problem then I either was beaten or locked up for the day."[59]

54 HIA 416 explained the process more fully in oral evidence as "the six pack". (Day180, p.5).
55 MIL 070.
56 MIL 055.
57 MIL 036.
58 Day 180, p.7.
59 MIL 044.

45 HIA 400 wrote:

> "Our cells were very basic with just a bed, a chair and a urine pot. We were woken up at six in the morning. We had to sit on the chair and we were not allowed to sit or lie on our beds during the day. If the prison officers caught you on your bed when they were doing their checks they would put you on report. We were only allowed out of our cells for meals. There was no one to talk to and nothing to do. I found somewhere in my room where I could hide things, so I made myself a chess board and made chess pieces out of papers for rolling tobacco. I would chew them and dry them on the radiator. I was able to play chess with myself to pass the time but I was always terrified of being caught."[60]

In oral evidence HIA 400 explained that in his experience any pastime which might be enjoyable was punished, as the period in closed borstal was intended to be harsh. He was worked so hard in PE that he vomited, but was made to clean it up and carry on; he also saw other boys vomiting.[61]

46 The above accounts of the closed section all occurred in the period 1977-1980, and (excluding the allegations against Officer Skillen) they constitute the majority of the allegations of physical abuse made concerning Millisle at this time. It is noticeable that the allegations are almost all non-specific: witnesses recalled being kicked or punched or beaten as regular occurrences. This suggests that there was a culture of low-level violence, coupled with an absence of serious violence, such that trainees did not suffer observable injuries. Governor McLaughlan said that if boys had been injured and required treatment the matron could not have kept it to herself and would have told him.[62]

47 Nonetheless, although the training provided in the closed section was meant to be "austere", even low-level violence was against Governor McLaughlan's stated policy of zero tolerance of physical abuse.[63] Furthermore, Rule 22 of the Prison Rules made it clear that only "necessary" force could be used to maintain order.[64] When asked why the majority of the allegations had related to the closed section, Duncan McLaughlan suggested that they occurred when the unit had not yet settled down.[65]

60 MIL 017-018.
61 MIL 018.
62 Day 182, p.69.
63 Day 182, p. 59.
64 MIL 10678.
65 Day 182, p.107.

48 Supporting this opinion, the Chairman of the Visiting Committee visited the closed section on 28 June 1978, seven months after it had been opened:

> "... A great change has taken place since my last visit. The staff have now settled in and any I spoke to showed an enthusiasm for the job which was lacking on my last visit when so many had recently arrived from the Maze and other prisons, and had not adjusted to the different atmosphere of Woburn. ...I have reflected recently on borstal training as I have known it at Woburn over the past fifteen years or so, and while the Institution has always been runn [sic] smoothly and efficiently from an administrative point of view, I think it could be said that there is evidence of a new dimension in training. This is hard to define, but mainly involves attitudes and rapport between Staff and Trainees. Also Trainees have been given more freedom to develop any potential they may have. The fact is that they are being 'stretched' rather than merely conforming."[66]

49 The Chairman put the change down to the enthusiasm of the Governor. It is possible that some of the abusive practices described by witnesses reflected approaches which staff had learnt in the other prisons from which they had transferred on the opening of the closed section at Millisle, and that they had not yet adopted the thinking of Governor McLaughlan on the treatment of trainees.

50 **We accept that there was on occasion low-level violence in the closed unit between 1977 and 1980. This was contrary to Governor McLaughlan's instructions and may have reflected working practices introduced by prison officers from other prisons in the early months of the closed section, but it was unacceptable and constituted systemic abuse.**

Transfer to the Open Borstal

51 At the end of the assessment period, trainees appeared before the Allocation and Training Board, which determined their training plans and made recommendations to the Review Body concerning their placement, which was preferably a move to the open section.[67] HIA 294 said that boys stayed in the closed borstal:

> "until you were good enough or they thought you were good enough".[68]

He spent six months in the closed unit.

66 MIL 28062.
67 MIL 20899.
68 MIL 065.

52 Despite his experience of the harsh conditions in the closed unit, HIA 400 tried to prolong his stay in the closed section, as some of the boys who had bullied him in Rathgael were in the open borstal and he was terrified of meeting them again. He therefore trod a fine line, misbehaving sufficiently to avoid promotion to the open unit while avoiding serious misconduct which might have resulted in a beating or being placed in solitary confinement (which he called being "put on the boards").[69] When a group of trainees were asked jokingly by an officer which of them did ***not*** want to be transferred to the open borstal, HIA 400 put his hand up, and was called to see the Governor the next day. He was given a job in the Governor's office, but it was a month later before he felt able to tell the Governor the real reason for wishing to stay in the closed section.

53 After some months' delay, HIA 400 was offered medication and was then transferred to the open unit by force, which he found highly distressing, though he admitted that in the end this made him stand up for himself and he outfaced the older trainees who had bullied him.[70] The process which HIA 400 experienced indicates not only considerable sensitivity and flexibility on the part of the Governor in meeting HIA 400's needs, but also the fundamental requirement for conformity, which was ultimately enforced. The transfer was badly handled and this constituted poor practice, but the example was isolated and it did not amount to systemic abuse.[71]

The Open Borstal

54 The model of care provided by Millisle open borstal was in many ways very similar to that of the training schools, but it also had characteristics associated with prison life. Features similar to those found in training schools were, for example, workshops for trade training, sports facilities, house units and a points system, but there was more regimentation, less family contact and less freedom of movement.

55 The trainees were divided into two house units, named Montgomery and Alexander, each under a housemaster, or assistant governor, who was expected to act in loco parentis for the trainees in his house.[72] According to HIA 416 there were two separate wings - "a green wing for country

69 Day 179, p. 6.
70 MIL 018-020.
71 Day 179, p.11.
72 MIL 141, 184, 611; Day 180, p.44.

people and a blue one for Belfast people". The distinction between the two groups was, he said, made by the officers and it reflected a social divide in the wider community, as the city boys considered themselves more streetwise than the country boys. HIA 416 said that there was, however, no distinction between the ways in which the two groups were treated.[73] Duncan McLaughlan denied that this distinction existed, and pointed out the management problems such an arrangement would create, as the number of trainees admitted from different areas was unpredictable.[74]

56 The main weekday occupation in the daytime was trade training in the workshops, with a view to providing skills for the trainees to enable them to obtain employment on discharge. Over time the subjects changed, reflecting developments in employment patterns. When the borstal was at Malone the options included:

> "tailoring, bootmaking, carpet-beating, carpentry, farm work and reconstruction/maintenance of buildings"

with handicrafts classes in basket-making, leatherwork and painting.[75] By 1979 the options available at Millisle were:

> "Mechanical Engineering, Joinery, Painting and Decorating, Bricklaying and Horticulture".[76]

HIA 416 recalled workshops for joinery and metal work in 1979.[77] HIA 374 was an apprentice bricklayer before his committal to borstal, and he continued his training in the bricklaying workshop.[78] One trainee who was an apprentice electrician prior to admission was permitted to study at the local technical college.[79]

57 A Visiting Committee member noted that some of the work undertaken in the workshops was repetitive and unproductive, but there were examples where the projects were of real benefit, for example in building stores and a garage,[80] making items for other institutions,[81] such as internal gates for the Maze prison, preparing a new altar for the Roman Catholic chapel in

73 MIL 072.
74 Day 182, p.43.
75 MIL 119.
76 MIL 120, 713
77 MIL 072.
78 MIL 050.
79 MIL 713.
80 MIL 24299.
81 MIL 24168.

Donaghadee, which had been destroyed,[82] converting an ambulance into a mobile toy library[83] or making toys for sale.

58 Some trainees were allocated to tasks which were necessary to the running of the borstal.[84] HIA 212, for example, worked in the laundry and cleaned windows, including those of the prison officers' houses, which were "just across from the Woburn House complex".[85] HIA 248 said he worked in the officers' mess up the hill, starting with clearing up after their breakfast, but according to Duncan McLaughlin the 'mess' was no more than a small room in the main house with facilities for snacks.[86] HIA 248 also worked in the kitchen from 7am every day preparing meals for the trainees; he enjoyed this work while other opportunities to do woodwork, crafts or PE did not interest him. After a while he was given a red armband as an orderly, and this allowed him to move freely in the borstal grounds.[87]

59 The educational attainments of many trainees were poor. As early as 1960 a special teacher was brought in to help trainees struggling with education. In 1965 compulsory education was introduced, amounting to two evening classes a week of two hours each.[88] It was noted in 1966 that 69% of the trainees were educationally retarded, and by 1968 this had gone up to 74%.[89] In 1969 the attainments of 56% of the trainees equated with those of an eight-year-old.[90] Of the 149 committed to borstal in 1979, 100 were considered to have special educational needs.[91]

60 Duncan McLaughlan wrote that:

> "Formal education ranged from remedial education to what was then known as the General Certificate of Education."[92]

There was a team of three full-time teachers, led by a Head of Education, and a large number of part-time teachers. The library was reported to be well stocked.[93]

82 MIL 499.
83 MIL 27780.
84 MIL 713.
85 MIL 081.
86 Day 182, p. 45.
87 MIL 056.
88 MIL 180, 27780, 27903.
89 MIL 27925.
90 MIL 27937.
91 MIL 710-711.
92 MIL 713.
93 MIL 27914.

61 Sporting activities were also encouraged, and there are references in the records to football, cricket, basketball, athletics, swimming, darts and table tennis.[94] On Saturdays the afternoon was given over to football, cricket and swimming for trainees who did not have visitors.[95] In 1970 a new gymnasium was opened. There was also an annual Mourne Wall Walk, and it was reported to the Visiting Committee on 2 June 1980 that this had been completed in record time.[96]

62 HIA 416 said that during the day the trainees went to the gym to exercise, and complained that in the winter they went outside to exercise in the rain, though they were locked up all day in the summer. He said that they also did boxing, but this was denied by Governor McLaughlan, who said he was firmly opposed to boxing and would not have permitted it.[97] [98] The beach was used for a short season,[99] but in later years it was avoided because of the poor quality of the water.[100]

63 HIA 400 described 'murder ball', in which there were:

> " two teams of ten, a medicine ball in the middle and a big mat at each side of the room. The object of the game was for each team to try to get the ball on to the other mat by any means necessary. You were allowed to kick and punch. I liked that game and I thought it was a good way to allow all the boys to get rid of any tension."[101]

He added that as soon as the game started there was a free-for-all fight between the two teams, regardless of where the ball was.[102] As Governor, Duncan McLaughlan did not recognise this description of the game, saying that all the players had to sit on the ground and only move by shuffling.[103]

64 On Sundays trainees from the open section attended church services in the local community,[104] and HIA 416 recalled that Officer Skillen accompanied Roman Catholic boys to Mass.[105] There was religious instruction on Sunday

94 MIL 24255, 24298.
95 MIL 121.
96 MIL 748.
97 MIL 071.
98 Day 182, p.38.
99 MIL 24255.
100 Day 182, p.106.
101 MIL 020.
102 Day 179, p. 19.
103 Day 182, pp.41 and 42.
104 Day 182, p.105.
105 MIL 073.

afternoons, but it is unclear what proportion of the trainees participated in any of these activities.[106]

65 Although there was much less emphasis on chores than in the closed borstal, they were still a feature of life in the open unit. The governor inspected the cells for cleanliness on Saturday mornings and "your cell had to be twice as clean" according to HIA 416. They used a big wooden box with bricks in it and a blanket underneath as a buffer for the floors, and the trainees had to buffer the floors as a punishment. The buffer was very heavy and HIA 416 attributed his tennis elbows to this manual labour.[107] Duncan McLaughlan wrote that there was an electric floor polisher.

66 In general, life was more relaxed in the open section. Trainees were no longer required to make bed packs, but simply made their beds. Trainees were allowed to wear jeans in the open borstal, as against the black uniforms in the closed unit.[108] There were no complaints about food, and the Visiting Committee frequently commented on its excellence.[109] Leisure pursuits included first aid training, motor maintenance and adventure activities, as well as snooker and television. [110]

67 Duncan McLaughlan also wanted to get trainees out into the local community. In 1975, soon after he had taken up post, he reported that trainees on special privileges went for supervised walks in the neighbourhood, for example, and others played football matches against teams in the neighbourhood. Plans were in hand for camping trips and canoeing, and arrangements were being made to redecorate Corrymeela.[111]

68 There were parades, at which trainees could request to see the governor or the doctor or the chaplain. There were different chaplains for the different denominations. Medical services were provided by a local doctor, who "attended each day and on demand as required".[112] There was also a resident matron.[113]

69 When HIA 416 was suffering from sciatica (though he was unaware at the time that this was the problem), he was unable to stand straight to attention at parades, and was punched for failing to do so. He was

106 MIL 597.
107 MIL 071.
108 MIL 072.
109 MIL 423, 422, 386, 351, 24807.
110 MIL 713.
111 MIL 336.
112 MIL 714.
113 MIL 614.

suspected of malingering, but he was nonetheless taken to hospital for an x-ray, he was placed in a hospital room for three days, and he was put on light duties following the intervention of the governor.[114] [115]

The Progression System

70 The Prison (Northern Ireland) Act 1953 set a maximum of three years for borstal training, with the minimum being normally nine months unless a special case were made.[116] This was reduced under the Treatment of Offenders (Northern Ireland) Act 1968 so that the minimum period of borstal training was six months and the maximum two years.[117]

71 Under the Progression (Grade) System trainees could move up through four (or possibly five) grades, depending on their conduct. The further they progressed, the greater the freedom allowed to them and the greater the rewards in terms of parcels and visits permitted. Equally, if a trainee was involved in misconduct, such as fighting, absconding or cheek to staff, he could be downgraded. Originally, the grades appear to have been labelled Ungraded, A, B, Probationary and Special, plus a Penal Class which involved stone-breaking. Later, the grades were titled Entrant, General I, II and III, Special I and II and Group Leader or Prefect.[118] In the 1970s the grades were labelled 1, 2, 3, (and possibly 3B) and 4, the 'special' grade. Typically a trainee spent a few months in each grade, though accelerated promotion was possible.[119]

72 Records were kept on each trainee.[120] Every month officers and instructors provided progress reports which were collated by the house principal officers and discussed at house boards.[121] There was then an internal Review Board chaired by the governor where recommendations on promotions were discussed. Decisions on grading were taken by the Reviewing Board, which met monthly and included representatives from the Northern Ireland Office and the Prison Service headquarters.[122] [123] The Board essentially endorsed the recommendations made by the internal

114 MIL 073.
115 Day 180, p.39.
116 MIL 10658.
117 MIL 163, 10950.
118 MIL 603.
119 MIL 122, 162, 181, 712.
120 Day 182, pp. 36 and 37.
121 MIL 182-183.
122 MIL 168
123 Day 182, pp.49 and 50.

review system, but they also interviewed all newly admitted trainees and any who had been downgraded. It was the Visiting Committee, however, which made recommendations to the Northern Ireland Office for the release of trainees.[124]

73 An undated table described the privileges awarded to the differing grades in terms of letters, visits, pre-decimal pocket money and status.[125] 'Stripes' were awarded to match the grade and the loss of a stripe was one of the possible penalties.[126] A red armband was awarded to the 'special' grade, indicating that they had the freedom to move around the site.[127]

74 The longer trainees stayed at Millisle the later they were permitted to stay up and remain in association, playing badminton, billiards and table tennis. Those who had been there fifteen months or more were also allowed to smoke.[128]

75 When boys had worked their way up through the grades, the final stage was known as 'special privileges' and it applied to trainees in their final three months before discharge. It was still possible to lose such privileges, and witnesses described their apprehension when officers or other residents attempted to engage them in behaviour which would have delayed release.[129]

Punishments

76 Under Rule 84 of the 1954 Prison Rules the governor was authorised to deal with breaches of discipline such as:

> "idleness, carelessness, abuse of privilege, non-conformity to parole decisions, irreverent behaviour during prayers, disrespect towards officers/visitors, repeated/groundless complaints etc."[130]

77 The penalties he could apply were:

> "administration of a caution, removal from activities other than work, award of extra work, forfeiture of right to additional letters/visits, stoppage of gratuities or earnings, reduction in grade, delay in promotion to a higher grade, [and] confinement to room for 3 days."[131]

124 MIL 122-123, 162, 172, 712.
125 MIL 603.
126 MIL 122.
127 MIL 056.
128 MIL 122.
129 See also paragraphs 95-97 on Discharge and Aftercare.
130 MIL 125.
131 MIL 125.

78 Statistics indicate that the commonest penalties were loss of grade or privileges and stoppage of earnings, with confinement to room following on. These accounted for 96% of punishments in 1972-1976. By 1979 extra work was becoming a more frequent punishment.[132] With the exception of 1974, when fifteen trainees were caned, corporal punishment was scarcely ever used in the later years.[133]

79 HIA 272's recollection of solitary confinement was that he:

> "had to stand facing the wall for two or three hours at a time and answer questions on the Bible, which was the only reading material I had."[134]

In oral evidence he added that he did not read the Bible and had not been able to answer the questions.[135] Duncan McLaughlan said that as Governor he refused to use solitary confinement, and the cells were turned into a series of rooms to teach painting and decorating,[136] though there were still rooms for time out.[137]

80 If a trainee was punished with loss of association he was not permitted to join in leisure-time activities, which were seen as a privilege. Duncan McLaughlan said that trainees subject to loss of association had to go to their bedrooms or remain in the common room. HIA 272 wrote:

> "In the evening, I had to sit in a small metal box with a narrow seat from 6 until 10 p.m. for a month until my punishment was complete. It was called the doggie box as it was in the same shape as the starting boxes at a greyhound race-track. This was an isolating and depressing experience. I had no-one to chat to in the evening."[138]

Duncan McLaughlan said he had never heard of the "doggie box" and could not imagine what was being described.[139]

81 The rules for the application of corporal punishment were laid down in detail in the Prison Rules, and the requirements were demanding and precise.[140] The evidence of officers and former trainees alike suggests that

132 MIL 594.
133 MIL 205.
134 MIL 011.
135 Day 178, pp.42 and 43.
136 Day 182, p.17.
137 Day 182, pp.21 and 22.
138 MIL 011.
139 Day 182, pp.25 and 26.
140 MIL 10228-10229, 10680.

the Prison Rules were adhered to closely. It was for the Visiting Committee to decide if a trainee were to be caned and this is addressed more fully in the section below on the role of the Visiting Committee.[141]

82 HIA 262 said that he was caned for absconding by Officer Skillen and ML 6, but his statement did not indicate that he was alleging physical abuse.[142] Prison Service records were unable to identify anyone who might have been ML 6. According to Duncan McLaughlan, corporal punishment was awarded by the Visiting Committee on three occasions during his tenure from 1975 to 1980. He was opposed to corporal punishment,[143] but stated that:

> "the cane was applied by Mr Skillen and that he did so within the terms required under the Prison Rules".[144]

On one occasion the caning was stopped because the Medical Officer, who was required to be present, became unwell.[145]

Absconding

83 The establishment was intentionally open, and the trainees therefore had opportunities to abscond. Duncan McLaughlan described the usual process followed at Millisle:

> "When a young person absconded, staff searched the immediate area of the Borstal; if this was unsuccessful, the police were notified and they took over. A returned absconder would be interviewed by an assistant governor. An absconder would face formal disciplinary proceedings involving adjudication by the Visiting Committee. This Committee would decide whether or not a young person was guilty of an offence and if guilty, the sanction which should apply. Such sanctions could have included corporal punishment or loss of grade or privileges. Absconding episodes were recorded in the Governor's Journal."[146]

84 Stephen Davis said that absconding appeared to be a problem, citing figures for the period July 1975 to December 1980.[147] MZ 1 concurred; he was an officer in the open borstal for nine months, but requested

141 See paras. 119-121.
142 MIL 036.
143 Day 182, pp.53 and 54.
144 MIL 718.
145 MIL 718.
146 MIL 717.
147 MIL 160-161.

a transfer as he felt unsuited to the role. In oral evidence he said that abscondings were so frequent that "at night you could have set your watch by it", with boys smashing dormitory windows in order to escape, in one instance jumping onto the roof of the Chief Officer's car, which happened to be parked underneath.[148]

85 HIA 212 did not return when allowed out on parole, and so when he was apprehended he was sent to Crumlin Road Jail, where he completed his sentence.[149] HIA 272 who had absconded after only ten weeks at Millisle was at large for eight months before being apprehended, but this was at the height of the Troubles when the police would not have had safe access to his home area in west Belfast and the Army patrolled the area.[150]

86 The statistics published by the Ministry of Home Affairs, however, indicate that in the later years absconding was limited, and did not reach the levels experienced at Rathgael or St Patrick's, even though Millisle received some boys from these training schools specifically because of the frequency of their absconding. There were occasional peaks, such as May 1976 when six absconded and June 1980 when five ran away, but the general picture was one of stability. In the last four years prior to closure there were no abscondings in 34 of the 48 months, and in the eighteen months from March 1977 to September 1978 only three boys absconded. The figures for trainees failing to return from leave were similarly low.[151] Duncan McLaughlan was unable to offer an explanation for the decreasing level of absconding, and said he had no specific strategy to reduce running away other than treating people decently.[152] Trainees would, of course, have been aware that further absconding could result in their having to complete their full sentence in prison.

87 To those used to working in secure establishments any absconding may well have been seen as a serious problem but, by comparison with other open institutions for a similar clientele, Millisle's record was good. No one ever absconded from the closed section at Millisle.

148 Day 181, pp.51 and 52.
149 MIL 081.
150 Day 178, p.47.
151 MIL 90046.
152 Day 182, pp.97 and 98.

The Troubles

88 Millisle took both Protestant and Catholic offenders, and in view of the serious intercommunity discord from 1969 onwards, problems could have been anticipated, both within the trainee group and between officers and trainees. Duncan McLaughlan, who was at Millisle from 1975 onwards, said that there was no sectarianism among officers, and that while there were disagreements between trainees, this was never a serious issue.[153] MZ 1 went even further; he said there was no sectarian division between the boys and they just accepted the situation.[154]

89 There was, however, some scattered evidence of difficulties. HIA 162 said that there was a sectarian split in the dining hall and the common room, not organised by staff but with the denominational groupings of trainees gravitating towards their own.[155] The division between Roman Catholic and Protestant trainees may have underlain some of the bullying described by witnesses. HIA 262 wrote:

> "Because we were Catholic we were seriously under the heel."[156]

90 The sectarian division was said to involve the officers. HIA 400 described how an officer who was good to him told him:

> "to go into the Catholic boys' room while they were out and rip up their books. I didn't want to do it but I didn't dare say no to him."[157] [158]

The same officer put him up to fight another boy, "for his entertainment", he thought.[159]

91 The tension grew when, on 27 August 1979, eighteen soldiers were killed by IRA bombs at Warrenpoint near Newry, HIA 416's home town. When the news was announced, another trainee from Newry "let out a roar", such that an officer entered the room and called HIA 416 and the other trainee "Fenian bastards".[160] After that he felt under greater threat of physical abuse from other trainees.

153 Day 182, pp.40 and 41.
154 Day 181, p.43.
155 Day 178, pp.69 and 70.
156 MIL 036.
157 MIL 021.
158 Day 179, p.20.
159 MIL 021.
160 MIL 074.

92 Further to the problems within Millisle, the Probation Service had difficulty undertaking aftercare supervision in some communities.[161]

93 In his report for 1970 the Catholic Chaplain commended Millisle for the "immense amount of goodwill and co-operation among all members of staff" at a time of turmoil in the community, and he regretted that "such good relations never reach the headlines".[162] At the Visiting Committee on 7 July 1972 sectarian tension was discussed and a member suggested that any troublemakers should be moved.[163] In his report to the Visiting Committee, another member wrote concerning his visit on 24 April 1974 that the:

> "Governor and staff deserve credit for boys of both religions working, living and playing together over the last few years when this has been impossible in other penal establishments and indeed in the community at large."[164]

In 1980 the Visiting Committee questioned whether there was sectarian discrimination. The deputy governor denied discrimination but said that the question arose when there was a denominational imbalance, and that it was seasonal.[165]

94 On balance, in view of the problems occurring elsewhere in the province during the Troubles and taking account of Millisle's remit to admit both Catholics and Protestants, the staff at Millisle appear to have been as successful as could have been hoped in keeping the establishment on an even keel.

Discharge and Aftercare

95 As trainees approached the end of their training, they hoped to be put on 'special privileges' by the Licensing Board, which meant that three months later they were due for discharge. Witnesses reported that this left them vulnerable to bullying and other discriminatory behaviour, as they were unable to retaliate without risking the label of being a 'borstal failure', which would have led to a delayed discharge, or to a return to the closed borstal for the remainder of their full sentence if failed at three consecutive Boards. Furthermore, under the Treatment of Offenders Act

161 MIL 24225.
162 MIL 24173.
163 MIL 508.
164 MIL 406.
165 MIL 25006.

(Northern Ireland) 1968 it was not permitted to serve a second borstal sentence; any further offending could have led to prison.[166]

96 HIA 400 said that one officer used to whisper threats in his ear that he intended to make him a borstal failure, and he teased him publicly in the dining hall, such that HIA 400 reacted and was threatened with being put on report. However, the Governor, with whom HIA 400 got on well, overturned the officer's recommendation of failure and he was discharged ten weeks later.[167]

97 Similarly, HIA 416 said:

> "... when I received my special privileges, a screw was trying to break me so that I would lose them".[168]

He added further detail in oral evidence.[169] HIA 416 was discharged after a year, but he alleged that he knew not to report MZ 1, who punched and slapped him, as he "would end up having to serve the full three years of a sentence".[170] MZ 1 wrote that he worked in the control room and not in the dormitories where this is alleged to have taken place.[171] Records indicate that MZ 1 was considered to be unsuited to borstal work as he was an inflexible disciplinarian.[172]

98 On being released, trainees were subject to licence and were supervised by probation officers.[173] [174] Unlike the training schools, Millisle had no responsibility for aftercare and does not seem to have followed up any trainees to learn if they had been successful.

Staffing

99 As noted above, the staff were mostly prison officers in both the closed and open borstals. Once an officer had completed his probationary period he was confirmed in post as a prison officer. Officers working in borstals received no specific training in the custody of young offenders.[175] Class officers looked after specific house units or landings in the closed section. There was also a physical training officer.

166 MIL 114.
167 MIL 021-022.
168 MIL 075.
169 Day 180, p. 28.
170 MIL 074.
171 MIL 798.
172 MIL 789, 21994, 22327.
173 MIL 24300.
174 Day 182, pp.106 and 107.
175 MIL 719.

100 In addition to the prison officers there were a number of civilian staff at Millisle, such as the instructors in the workshops, teachers, nightwatchmen, matron and seamstress. Among them were a chief vocational training officer and an education officer.[176] There was also a visiting psychiatrist and a visiting dentist.[177]

101 There was a clear hierarchy of accountability within the Prison Service. Above the officers there were senior officers and principal officers, who accounted to the chief officer. Above him were the two assistant governors, referred to in borstals as housemasters, and overall there was the governor, who was responsible for almost all aspects of the running of Millisle.[178]

102 The housemasters played an important role in organising activities such as inter-house sports, in overseeing the education and vocational training of individual trainees, and in maintaining family links, including visiting their families and arranging employment for trainees on their release.[179] The welfare officer at Rathgael also assisted when support in the community was required.[180]

103 There appears to have been something of a division between the governor grades and the officers at times. While the governor's instructions were explicitly obeyed, the officer grades developed a culture of their own, which had its own way of dealing with matters. The evidence of the witnesses includes a number of instances in which governors protected trainees from officers, and witnesses appear to consider that governors were humane and fair, if strict at times, but they felt that things went on of which the governors were unaware. HIA 400, for example, said that officers behaved differently when the governor was present, and as a result the governor had no realistic understanding of what was going on.[181]

104 Duncan McLaughlan said that there were in all about sixty staff in the open borstal and a further sixty staff were added with the opening of the closed section. About thirty would have been resident on site, and could therefore have been available in the event of a crisis or if help were needed to cover sickness, other absences or additional duties. He thought he knew most, but not all, staff by name.[182]

176 MIL 714.
177 MIL 288, 24299.
178 MIL 714.
179 MIL 124.
180 MIL 714.
181 Day 179, pp.8 to 12.
182 Day 182, p.31.

105 In May 1974 the Visiting Committee raised concerns about the number of staff, stating in a letter to the NIO that Millisle had vacancies for ten officers.[183] The Prison Service faced serious recruitment difficulties and at that time they were 650 staff short in the province as a whole, such that volunteers were drafted from England and Scotland, but overall Millisle does not seem to have suffered unduly from shortages.[184]

106 Prison Officers were expected to abide by a Code of Discipline which spelt out what was expected of them in some detail.[185] Duncan McLaughlan said that if officers stayed within the boundary of acceptable conduct he supported them.[186]

Governance

107 Under the Prison (Northern Ireland) Act 1953, the Ministry of Home Affairs was made responsible for prisons. The Prison Service was within the purview of the Ministry of Home Affairs, and the governor of Millisle was responsible to the director of prisons. Under direct rule from 1972 to 1980 - the period relating to nine of the ten applicants - the Prison Service was the responsibility of the Northern Ireland Office.[187] The governor had considerable delegated powers, and was responsible for almost all aspects of the running of the borstal, including the finances, administration, human resources, public relations, security and all aspects of the care of the trainees, though there were some decisions taken by the Visiting Committee and others where the MoHA or NIO gave authorisation.

108 The governor was therefore in a position to influence the tone of the institution. It was customary in the Northern Ireland Prison Service (NIPS) for governors to be promoted within the service, but in the 1970s there was a shortage of suitable candidates and so secondments were sought from England. Duncan McLaughlan, who was Assistant Governor of Millisle for three months in 1972-73 and Governor for the last six years prior to closure from 1975 to 1980, was initially seconded in this way. He provided helpful evidence, both in his statement and orally, as his tenure covered three years when Millisle was only an open borstal and three years when both the open and closed sections were in operation. It was also

183 MIL 24761.
184 MIL 394, 24764.
185 MIL 604-606.
186 Day 182, p.60.
187 MIL 117.

the period when seven of the ten applicants served their sentences at Millisle.[188]

109 Duncan McLaughlan was a keen exponent of "management by walking about" and, when on duty, he made a practice of visiting the whole borstal every morning, afternoon and evening, as he felt that this was a good way to "impose his will on the Establishment".[189] MZ 1, an officer who was accustomed to the traditional distance maintained between governor and prisoners in adult prisons, was alarmed to see him playing snooker with the trainees.[190]

110 The governor was required to investigate and report any serious misconduct to the Northern Ireland Office, such as "escape, smuggling, mutiny, assault on an officer, gross violence etc."[191] Duncan McLaughlan said that his contact with Prison Service Headquarters largely related to financial and personnel matters, although he participated in meetings on general prison service matters.[192] It was the practice for governors to prepare annual reports, but this ceased as it was not a legal requirement, though statistical returns were still submitted on:

> "admissions and releases, previous releases, accommodation, training, education and absconding episodes."[193]

Finance

111 As part of the Northern Ireland Prison Service Millisle was funded directly by the Government through the Ministry of Home Affairs or, from 1972, through the Northern Ireland Office. The Government incurred considerable expenditure not only in the building of the closed borstal but also in the addition of the classrooms, workshops, gymnasium and staff housing to augment the original Woburn House.

112 A request for a £100,000 indoor swimming pool was turned down by the Northern Ireland Office.[194] Otherwise there has been no evidence that shortage of staffing or other resources affected the quality of service provided by Millisle or impacted on the circumstances of any of the

188 MIL 706-724.
189 MIL 719.
190 Day 181, p.31.
191 MIL 125.
192 MIL 719-720.
193 MIL 720.
194 MIL 332, 340,356.

allegations made by the Inquiry's witnesses or recorded historically. We have therefore not inquired further into this subject.

Inspections and the Visiting Committee

113 There was no system of inspections for prisons and borstals in Northern Ireland until 1981, after the closure of Millisle.[195]

114 Some external influence was exercised by the Northern Ireland Office and Prison Service, as their representatives were members of the Review Board, which determined the progression of the trainees through the grades and their eventual dates of discharge, but according to Duncan McLaughlan this committee largely rubber-stamped recommendations made by an internal committee.

115 The main external check on the work of the borstal was the Visiting Committee, appointed by the Minister under Section 11 of the Prison (Northern Ireland) Act 1953.[196] It was a statutory requirement that there should be at least six members, but usually there were a dozen and in 1979 there were eighteen.[197] Members were expected, in the words of the May Committee, to be "well informed and acute but friendly watchdogs of the public interest".[198] Stephen Davis described the Visiting Committees as "both supportive and challenging".[199]

116 The Committee had two main roles. The first was for members to visit and apprise themselves of the quality of service being provided. The second was to adjudicate when a recommendation was presented to them under Rule 175 of the 1954 Prison Rules that a trainee had been involved in serious misconduct and merited corporal punishment.[200] The minutes of their monthly meetings have survived from 1972 to 1977 and 1980, and they throw light on a wide range of matters.[201]

117 The meetings typically heard a report from the governor on the occupancy, admissions and discharges in the previous month, staff changes and any major problems or developments. They received the reports of the two members delegated to visit during the previous month. They discussed

195 MIL 118.
196 MIL 10693.
197 MIL 582.
198 MIL 580.
199 Day 182, p.11.
200 MIL 125-127, 580.
201 MIL 24613-25039.

issues raised by members, and for a time in 1976 to 1977 they interviewed all trainees admitted during the previous month.[202]

118 The issues raised by members were very varied. In 1972, for example, they made visits to borstals in England, which reassured them about the service offered at Millisle, which "compared most favourably with the best they had been privileged to visit in England".[203] They decided, subject to Ministry approval, to invite members of the judiciary to visit the borstal.[204] To help trainees obtain employment in painting and decorating they met a delegation of trade unionists, to see if trainees could obtain union membership.[205] Following a visit by a member of the Committee, they advocated the fitting of half-doors on the lavatories.[206] The proposal for a heated indoor swimming pool was discussed on a number of occasions, and the Committee was not pleased when the idea was turned down on financial grounds in a brief communication from the Ministry.[207] It was the Visiting Committee which initiated discussion about single rooms.[208] Occasionally they discussed concerns raised about individuals, such as the exceptional violence of one trainee and the challenges this posed.[209] On one occasion they happened to meet the day after new Prison Rules came into force and so copies were promptly circulated to Visiting Committee members.[210]

119 The most contentious issue proved to be corporal punishment. When a trainee committed a serious misdemeanour, such as absconding, the case was presented to an emergency meeting of the Committee, often made up of only two or three members. They decided on the appropriate penalty, which was then reported to the Northern Ireland Office.

120 As the newly arrived Governor, Duncan McLaughlan was opposed to corporal punishment, and after the Visiting Committee had decided on 15 August 1975 that it should be applied, he chose not to implement their decision. Some months later he took advantage of a social occasion where he happened to meet Merlyn Rees, the Secretary of State for Northern Ireland, and Lord Donaldson, the Minister for Prisons, to explain

202 MIL 24927, 24938, 24939.
203 MIL 549, 24635.
204 MIL 414.
205 MIL 469.
206 MIL 519.
207 MIL 355, 356, 340, 332.
208 MIL 24698.
209 MIL 300.
210 MIL 478.

his position on corporal punishment. By this time corporal punishment had been abandoned in English borstals, and Lord Donaldson met two members of the Committee and requested that they reconsider their decision. The two members acquiesced but pointed out that they could not speak for the full Committee, who were not happy about the pressure being exerted on them. Lord Donaldson then asked that they should have a twelve-month trial period without applying corporal punishment, and before the trial period had been completed and evaluated, the Treatment of Offenders (Northern Ireland) Act 1976 abolished it. The Visiting Committee found the way in which this process had been manipulated highly irritating, but they decided to "suffer with good grace".[211] No action appears to have been taken, or complaint made, concerning Governor McLaughlan's refusal to implement a Visiting Committee decision.

121 The Visiting Committee had alternative penalties to corporal punishment at their disposal, and there was an example on 13 February 1975 when they decided that four trainees who had absconded should be subject to forfeiture of privileges, stoppage of earnings, reduction in grade, confinement to their rooms and return to Armagh Prison.[212]

122 If the Visiting Committee considered a boy "incorrigible" or exercising a bad influence on other inmates, they could refer the matter to the Minister who had the authority under the Prison (Northern Ireland) Act 1953 to have the trainee imprisoned elsewhere.

123 Trainees had the right to speak to members of the Visiting Committee "out of sight, out of hearing of staff", but according to HIA 400 this was a farce as trainees were warned by officers not to speak to Committee members.[213] Reports of visits mostly describe practical matters such as the cleanliness of the buildings, and there are almost no indications of any conversations between trainees and Visiting Committee members, though there is an example on 4 January 1976 of a of boy wanting to speak to a Visiting Committee member.[214]

124 The Committee's contribution in advising the governor on the main issues facing staff was therefore severely limited. Duncan McLaughlan said in oral evidence that the Committee's visits were valuable, but within limits,

211 MIL 216, 298, 299, 309, 311, 312, 316-318, 719, 763.
212 MIL 345.
213 Day 179, pp.30 and 31.
214 MIL 556.

as staff would not have discussed deeper issues with them.[215] Members never brought forward any complaints from trainees of assaults by staff.[216]

125 At their final meeting on 1 September 1980 the Visiting Committee expressed considerable dissatisfaction with the closure of the borstal and the ending of the system as a whole, as under the YOC system trainees no longer had the incentive to work towards early release.[217] The Committee was reorganised to function for the following four months as the Visiting Committee to Millisle in its brief role as a Youth Offender Centre before its final closure.

126 In summary, both of the main roles of the Visiting Committee - visiting and authorising punishment - acted as checks on the powers of the staff. Without the visits of the Visiting Committee members there was little external scrutiny and complaints were dealt with internally. The trainees were therefore relatively powerless and vulnerable, with few forms of redress other than rebellion. Although the Committee had few powers, by providing a presence of which the staff were aware and which, in extremis, offered the trainees a listening ear, the Visiting Committee probably played a useful role as a safety valve.

Allegations of Abuse by Officers

Overview

127 The following categories of alleged abuse are addressed in this section:

(a) Allegations of physical, sexual and emotional abuse by Officer Skillen

(b) Allegations of physical abuse recorded in the documentation

(c) Allegations of physical abuse made by applicants in their statements or oral evidence

(d) Complaints

(e) Allegation of sexual abuse

(f) Allegations of emotional abuse

(g) Conclusions concerning allegations of abuse by staff

215 Day 182, p.73.
216 Day 182, p.75.
217 MIL 752.

(a) Allegations of Physical, Sexual and Emotional Abuse by Officer Skillen

128 Desmond James Skillen, known to colleagues and trainees alike as 'Punchy', was born on 2 January 1926 and he died on 5 December 1994. He joined the Prison Service on 30 June 1955, though it is not known when he commenced work at Millisle.[218] His personnel file was destroyed in 2000, and so very little else is recorded about him.[219]

129 He earned his nickname by acting as sparring partner for a well-known boxer. Officer Skillen was therefore a competent boxer himself, and was said to have shown "every sign of taking too much punishment". Two witnesses said he punched boys, though that was not alleged to be his main modus operandi in abusing boys.[220] Duncan McLaughlan, as Governor, saw Officer Skillen as sincere and honest, somewhat slow on the uptake and at times the subject of banter among the officers. He had warm memories of him and his "lovely family", and he had never heard reports of any abusive misconduct on the part of Officer Skillen.[221]

130 Although it is not clear when Officer Skillen commenced work at Millisle, he was already in post when Governor McLaughlan took over in 1975; Officer Skillen would have been 48 years old at that time. He was the officer nominated to apply corporal punishment when required, as HIA 362 found out.[222] According to Governor McLaughlan it is not known why Officer Skillen was selected for this role, but he said that he always carried out his duties in accordance with Prison Rules.

131 Officer Skillen was responsible for running the laundry, which was sited on the ground floor of the main house. Visitors' reports on the laundry were always satisfactory. When the Chairman of the Visiting Committee inspected the laundry on 12 February 1973 he noted "Mr Skillen getting the best from his boys as usual."[223] In the Governor's annual report of 1974 Officer Skillen was commended for the very efficient way he ran the laundry.[224] The next Governor, McLaughlan recalled that:

> "…when I visited there the atmosphere presented as good-humoured and relaxed."[225]

218 MIL 20305.
219 MIL 087.
220 Day 178, pp.33 and 34.
221 Day 182, p.62.
222 MIL 718.
223 MIL 488.
224 MIL 24300.
225 MIL 722.

132 From the evidence of witnesses it seems that he was the only officer who worked in the laundry, and at any one time he had one or more trainees who worked with him. Officer Skillen is said to have treated them well, and when he abused other trainees his assistants participated in the abuse, for example by holding boys down while he assaulted them.

133 HIA 272 wrote that a few hours after his arrival at Millisle he was told to report to the laundry to collect his new uniform from Officer Skillen who was:

> "looking me up and down. He was so close to me that I could smell his breath. He suddenly grabbed my testicles and head-butted me at the same time. I was so shocked that I just stood there and did not react. Another officer and prisoner were present and they laughed as well. There was a large clothes dryer in the laundry, and Mr Skillen and two other members of staff bundled me into the machine and shut the door. One of them turned the machine on for a second and scared me to death. It was a terrifying experience and one which I will never forget."[226]

In oral evidence HIA 272 said that he had been "stunned" by being head-butted, (which he understood was a "ritual" of Officer Skillen) and frightened when he was put in a dryer for ten seconds. He complained to the Governor, who said the matter would be investigated.[227] We also received a statement referring to an admission ritual from ML 56. His application to be treated as a late applicant to the Inquiry was refused by the Chairman, and this refusal was upheld by the High Court. Nevertheless we have taken into account the statement which ML 56 then submitted to the Inquiry, but his allegations have not been investigated by the Inquiry and so we express no opinion on them. ML 56 said that when he was admitted, the newcomers were all lined up:

> "in the corridor in single file, Skillen came along and some of us got punched, others got a head butt or a 'dead leg'."[228]

134 Officer Skillen was said by most witnesses to act in a joking fashion when assaulting boys. Bystanders - both trainees and officers - laughed, though his victims found his attentions humiliating and not at all amusing. Most of the allegations related to abuse in the laundry, (though one allegation related to a mock sexual attack in the more public space of the dining

226 MIL 010.
227 Day 178, pp. 26, 28, 29.
228 MIL 835-836.

hall). All trainees had to visit the laundry at some point to collect clothes, but HIA 416 said he tried to go when he thought Officer Skillen would be absent, because of his reputation.

135 HIA 400 wrote that Officer Skillen:

> "played a 'game' where he would chase you and if he caught you he would pretend to touch you up. ...Periodically you would be sent to the laundry to get something, which was dangerous as he would throw a hammer or a spanner at you as soon as you appeared at the door. He hit a boy with a hammer and split his head open. It was part of his 'games' and everyone was afraid of being sent to the laundry... ."[229]

In oral evidence HIA 400 said that he saw Officer Skillen as being unlike other officers, simple, not very bright and "ogre-like".[230]

136 HIA 162 wrote of his personal experience with Officer Skillen:

> "He used to pretend to rub up against you in front of everyone and everyone thought it was funny. One day he hit me over the head with a hammer."[231]

HIA 162 saw Officer Skillen as "a bit of a character", and did not consider his simulation as sexual; he said it was funny to everyone except the trainee who was picked on.[232] ML 56 recalled that when this happened:

> "I can remember him getting that excited that he was foaming and dribbling at the mouth".[233]

137 Officer Skillen was quite open about some of his abusive behaviour. In the dining hall he approached boys from behind and simulated intercourse with them, causing laughter. HIA 374 wrote:

> "I only had a problem with one member of staff while I was there. I cannot remember his name but his nickname was 'Punchy'. He was a small man, stout with big lips. I will always remember his face. He worked in the laundry and once a week I had to bring my laundry down to be washed. He used to put his arms round me and try to kiss me. I could feel his erection against my body and he bent me over the washing machines and simulated sex with me. This was not a joke to him and he meant everything that he was doing."[234]

229 MIL 020.
230 Day 179, p.17.
231 MIL 044.
232 Day 178, pp.66 and 74.
233 MIL 836.
234 MIL 050.

In a statement to police he added that Officer Skillen had "fair hair, which was combed over" and that he:

> "would kiss at my face and slabber over me. This happened many times while I was at Millisle".[235]

In oral evidence HIA 374 said that he found the experience devastating, and it was repeated whenever he visited the laundry.[236]

138 HIA 416 went to the laundry one lunchtime to obtain a new jacket, as he thought Officer Skillen would be absent then:

> "There was a boy who worked in the laundry and I heard him shout 'Punchy, he is stealing jackets, get him, get him'. Punchy Skillen was the main guy in the laundry and he had a bad reputation. He made us call him boss. He would always punch you when you walked past him. Punchy then came in and closed the door and told me that I was going to get my star burst. Two boys held me over the press. Punchy then took my trousers down [leaving the underwear on] and shoved the shaft of a brush up my backside. After this I never went back near the laundry. I have never spoken to anyone about [this] incident."[237]

ML 56 reported that when he was trying on new jeans Officer Skillen head-butted him and stuck his finger up his back passage, causing him serious medical difficulties for some time afterwards entailing hospital care and a minor operation.[238]

139 Desmond Skillen was a practising Roman Catholic and HIA 416 said that, as a Catholic, he was particularly upset that Officer Skillen was prepared to assault a Catholic boy in this way. Officer Skillen escorted trainees to Mass. HIA 416 spoke of an occasion when he was present, recalling that Officer Skillen was enraged when two boys absconded at the end of Mass.[239] HIA 416 said that Officer Skillen "was even cursing. 'How dare they escape from the Lord's house?'"[240]

140 It is clear that Officer Skillen had a reputation among the trainees for physical abuse, sexual abuse (usually, but not always, in the form of a joke) and emotional abuse, in the humiliation of the boys he was attacking.

235 MIL 30187.
236 Day 179, p.45.
237 MIL 072.
238 MIL 836.
239 MIL 073.
240 Day 180, pp.17 and 18.

Although allegations were made against other officers, he stood out as the man whom the trainees feared. Officer LN 20 said he had heard of Officer Skillen's reputation, both from conversation with colleagues and from trainees who had been returned to the closed section where he worked, as they warned newcomers to avoid Officer Skillen.[241]

141 MZ 1, who was then a senior officer, said that Officer Skillen was known for being "a bit rough" with the trainees:

> "...on one occasion I heard from a member of staff that he had done something. He had I think hit or clashed somebody...and I said to him, 'You know, ...you would need to watch yourself, because this is not acceptable. You can't go around doing these things, because you are going to finish up in a lot of bother', and his idea was, 'Oh well', and I said, 'Well I am telling you, you just cannot do it.'"[242]

MZ 1 also told the chief officer, whose response was lackadaisical. He added that there would have been "Hell to play [sic] if the" number one" (that is, the governor) had known."[243]

142 Clearly Governor McLaughlan should have been informed. His predecessor had received a direct complaint about Officer Skillen from HIA 272 and his chief officer had received a complaint from another trainee, HIA 374, as well as from senior officer MZ 1. In a closed community such as a borstal Officer Skillen's behaviour would have been widely discussed, as LN 20 reported, and it would have been most unusual if more of Officer Skillen's exploits had not been passed on to senior staff. They clearly would not have known of some of the specific incidents described above, such as that recounted by HIA 416, but they should have been sufficiently aware of his unusual behaviour to know that his conduct was more than comical. He was clearly unsuited to the work.

143 Nonetheless, despite the physical, sexual and emotional abuse which Officer Skillen inflicted, Duncan McLaughlan said that he was quite unaware of it and he wrote that:

> "It would be unwise in the extreme for any prison governor to believe that he knew everything that went on in his establishment...or to maintain that every member of his staff was incapable of inflicting abuse on an inmate. ...I cannot therefore make any informed comment

241 Day 181, p.75.
242 Day 181, pp.35 and 36.
243 Day 181, pp.38 and 40.

> on the veracity of the allegations that have been made. If any one of those allegations is found to have substance then that behaviour was in direct contravention of the policies in place at the time and of my belief of how those under my care should be treated."[244]

In discussion of the failure of his staff to report Officer's Skillen's abuse of trainees, he added:

> "The culture of the Prison Service would be that you don't inform on your mates."[245]

144 It may be understandable that for a variety of human reasons officers failed to report Officer Skillen's behaviour, that senior officers failed to inform the governor, and that he failed to take decisive action. Whether understandable or not, the outcome was unacceptable. A number of trainees were physically and/or sexually attacked by Officer Skillen or were publicly humiliated by him, such that trainees generally were frightened of him and warned others to avoid him. Most of the witnesses alleging abuse by Officer Skillen were at Millisle during Governor McLaughlan's time; if his predecessor had taken action, therefore, trainees at a later date might well have avoided Officer Skillen's attentions.

145 **We consider Officer Skillen's behaviour to have been systemically abusive.**

146 In relation to the staff failure to report Officer Skillen's behaviour to senior staff, the Department of Justice argued that it would be "to misdescribe the nature of their failure to label it as a systems failure. Instead this was a people failure - a failure on the part of the officers to carry out what they knew to be their duty."[246] Clearly, whilst the individuals involved carry personal responsibility for such failure, the systems for which the Department's predecessors were responsible were not simply the mechanisms of identifying the people to whom such misconduct should be reported, but also the instilling of the values and attitudes in the staff that turn such a framework into good practice. To blame the staff is to abdicate such a responsibility. **We therefore consider it a systemic failure that at times information about Officer Skillen and his misconduct failed to reach senior officers who could have taken action, and that when it did reach them, as reported in the evidence, they failed to take action**.

244 MIL 723.
245 Day 182, p.67.
246 MIL 90082.

(b) Allegations of physical abuse recorded in the documentation

147 There were six instances identified in the records where allegations of physical abuse were made against staff, none of which related to any of the matters raised by applicants to the Inquiry.

148 In February 1962 allegations were made by a trainee's sister that he had been badly beaten by his housemaster; they were investigated and despite the bruising described by the sister the allegations were found to be unsubstantiated.[247]

149 In January 1963 a number of allegations were made by several trainees against ML 32, who was suspended. The allegations were investigated thoroughly, but again they were felt to be largely unsubstantiated, though action was taken by the Governor concerning ML 32's "lack of tact which was provocative to these trainees".[248]

150 On 17 January 1966 a teacher (Mr Anderson) asked ML 38 to remove a trainee from his class. The trainee complained about the assault he suffered while being placed in a cell. The Governor's investigations of allegations of assault against ML 38 were inconclusive, and no action was taken. As usual, the matter was reported to the Ministry.[249]

151 On 28 October 1971 the trainees refused to go to their dormitories after a concert on the grounds of "the brutality of the staff". The protest continued until lunchtime the following day. The Governor promised to listen to any trainee who brought him evidence of ill treatment, but in further discussions the points raised by trainees were their wish to wear their hair longer and have shorter sentences, as in English borstals.[250]

152 In 1975 a mother complained that her son had been assaulted, but there are no records of the investigation.[251]

153 It should be noted that these earlier instances do not suggest a pattern of systemic abuse. With the possible exception of the 1975 complaint, the allegations seem to have been properly investigated. A total of six incidents in the course of nearly twenty years is not exceptional, and the incident in 1971 indicates both the potential volatility of the clientele and the successful handling of the incident by the senior staff, who resolved it without serious injury.

247 MIL 128, 620-624.
248 MIL 128, 625-684.
249 MIL 129, 685-700.
250 MIL 25768.
251 MIL 130, 704, 715.

154 Two common factors are, however, noteworthy. The first is that physical assault was the common factor in most of the complaints. This continued to be the case in the allegations made by witnesses who came forward to the Inquiry. The second is that, with the possible exception of the action taken concerning ML 32, none of the complaints about physical abuse resulted in external investigation or action, despite the reported injuries.

155 There was one further alleged assault, not long before the closure of Millisle. A trainee who was not an applicant to the Inquiry alleged that he had been assaulted by two officers. The Governor immediately reported the matter to the police and suspended one of the officers, the other having gone off duty. He also noted the incident in the governor's log for 14 May 1980.[252] There was a police investigation, and the two officers were prosecuted but were found not guilty. They were transferred to work at Belfast Prison.[253]

156 Although this must have been a serious and most unusual matter in the management of the borstal, we were surprised that Duncan McLaughlan, who was Governor at the time, stated in oral evidence that he had no recollection of the occasion.[254] The significance of this occasion is that it was the first time that an incident was reported to police and was fully investigated by an external agency.

(c) Allegations of physical abuse made by applicants in their statements or oral evidence

157 Six of the ten applicants were discharged from Millisle during its last fifteen months, that is from October 1978 onwards. There are two main deductions that we draw from this. The first is that there were only four people who applied to be applicants who had been at Millisle during the preceding twenty-two years between the opening of the borstal in 1956 and 1978. Three of those were former trainees who made allegations against Officer Skillen in the mid-1970s, and only one other officer was named as abusive in this period.

158 The second deduction is that abusive conduct on the part of the officers increased in the final period prior to closure. It is always difficult to manage the closure of a residential establishment, and there may have been concerns for the future placement of the trainees and the redeployment of

252 MIL 130, 703, 748, 755-756.
253 MIL 25021, 25025.
254 Day 182, p. 81.

the staff. Both of these factors could have contributed to tensions resulting in difficult behaviour on the part of the trainees and misconduct on the part of the staff. Three of these six witnesses named Officer Skillen as their abuser, but between them they identified seven other officers as people who had physically abused them. None of these officers was named by more than one witness, but the sudden increase in allegations suggests that there were problems in Millisle's final months.

159 HIA 248 said:

> "There was a lot of physical abuse at Millisle. The staff were very aggressive and they physically punished us by slapping and kicking us if we did not do what we were told."[255]

Of two brothers on the staff he said:

> "They punched, kicked and slapped all the inmates if, for example, your cell wasn't clean or if it wasn't kept in the order they expected."[256]

160 An officer insisted that HIA 416 should shave; when the boy explained that he did not need to shave as he did not have any hair to shave, the officer smacked his face and said that he was to do as he was told.[257]

161 HIA 294 alleged that his Class Officer, ML 7, was "fond of lifting his hand" to him and punched him in the stomach and kidneys.[258] There was also an occasion when he was severely physically abused by the PE Instructor, ML 14 when he was:

> "kneeling down, like just putting my gutty on or something or taking it off, and I got this big mighty blow in the lung, which I don't know if it's cancerous or it's just a lesion, you know what I mean. ...But I reckon he done that with that blow cos I couldn't breathe nothing and me [sic] pride wouldn't make me cry or not in front of the other fellows, you know... ."[259]

He told the police that the officer (ML 14) found it funny.[260] ML 14 denied ever hitting any inmate at Millisle.[261] This is the only example of a specific allegation of excessive violence.

255 MIL 055.
256 MIL 055.
257 MIL 071, 799.
258 MIL 30078.
259 MIL 065.
260 MIL 30078.
261 MIL 30081.

162 The evidence in this section is supported by other passing references to physical discipline not quoted in this chapter, such as casual slapping reported in descriptions of other matters.[262]

163 While there may have been occasional instances of excessive force such as that described by HIA 294, it seems that the predominant problem was the prevalence of lower level violence in the assertion of authority through slapping, kicking and punching, as described already in the section on admission to the closed unit. We accepted that there was low-level violence in the closed unit between 1977 and 1980. This was contrary to Governor McLaughlan's instructions and may have reflected working practices introduced by prison officers from other prisons in the early months of the closed section, but it was unacceptable and we concluded that it constituted systemic abuse. (C.f. para. 50) The evidence in this section re-inforces that conclusion. **It is our further conclusion that on occasion low-level physical abuse was also reported in the open borstal, and that this was also systemic abuse**.

(d) Complaints

164 There was no formal complaints system, but a trainee could submit a petition to the Department on any matter although that petition was open to the scrutiny of the Governor.[263] We encountered no evidence of such petitions. Technically, "a trainee could make a complaint, request or allegation at any time".[264] Duncan McLaughlan recalled that:

> "Complaints and requests were generally about issues such as work allocation, not getting promotion to the next grade or requests for an extra visit. I do not now recall any allegations from trainees about abusive treatment from staff during my time as Governor in Millisle…".[265]

165 Any trainee could ask to see the governor (or the senior officer deputising for him) at the morning parade, when requests were also made to see the doctor or chaplain. The witnesses have indicated that they thought highly of the successive governors as being supportive and humane, and when they did complain, they were often, but not always, listened to. However, witnesses have also expressed scepticism about governors' knowledge of what was really going on within Millisle and about their ability to protect a trainee who made complaints about officers.

262 MIL 071-072.
263 MIL 716.
264 MIL 715.
265 MIL 715.

166 HIA 212 said:

> "I was in one time with the governor. I can't remember what I was charged with,...but the governor turned round and said to me 'Listen', he says, 'if officer whoever his name was says that you were riding up and down on a motorbike I'll believe him".[266]

167 HIA 374 complained about Officer Skillen to a senior member of staff who:

> "was sharp dressed, very presentable looking and had black hair and a black moustache. He simply dismissed what I told him and nothing was done."[267]

In a police interview, HIA 374 added that the senior officer had combed back hair and wore a number of gold rings on his fingers:

> "When I told him about what Punchy did to us in the laundry, he just laughed at me."[268]

168 HIA 272 complained about his treatment on admission by Officer Skillen, and was told that the matter would be investigated. He was then given the dining hall to scrub; having completed this task by lunchtime he was required to scrub it again after lunch. When he told LN 22, an officer, that it had been passed as clean by another officer:

> "He grabbed me by my ear and brought me back to the dining hall leaving black marks on the shiny floor as he went. He kicked the bucket of dirty water over the floor and told me to get it cleaned up by suppertime."[269]

169 He alleges that this continued for a month, and HIA 272 was then given another job, scrubbing the front of the building, with the warning not to look at any of the ladies who worked in the offices. He stated:

> "I was at breaking point at this stage. I complained to one of the staff members, [LN 24] as I felt I was being punished even though I had not done anything wrong. He shrugged his shoulders and said, 'We Officers stick together.' I understood this to mean that my treatment was because I had reported Mr Skillen for assault. After two months of scrubbing, I snapped and refused to do any more. I was reported to the Governor and punished by receiving five days in solitary confinement and 28 days of loss of night time association."[270]

266 Day 178, p.15.
267 MIL 050.
268 MIL 30187.
269 MIL 010.
270 MIL 010-011.

170 Complaints to senior officers were generally unsuccessful. In a closed community such as a prison or borstal there are often strong bonds of mutual reliance within the staff team, and it is unsurprising if complaints resulted in further repression as staff backed each other up. Even those officers who were considered the most supportive by the trainees will probably have been subject to pressure to turn a blind eye when they saw colleagues acting unprofessionally. Furthermore, officers who were less self-confident possibly looked to their more aggressive colleagues to give a lead in controlling the trainees and creating an atmosphere of conformity. HIA 400 said:

> "There were some prison officers who were very noticeably afraid of the job, and they were afraid of the boys, and they were afraid of the other staff. So they just put their heads down and got the day in".[271]

171 There was therefore a general reluctance to complain on the part of trainees, partly because it was seen as pointless, on the assumption that senior staff would support the officers, and partly because of fear of retaliation if action were taken. HIA 248 also pointed out that in his experience staff violence was not gratuitous, but was punishment for wrongdoing, so that both officers and trainees felt that it was justified.[272]

172 In taking account of the support offered by colleagues to each other, it has to be remembered that the solidarity of the Prison Service community was of great importance to officers throughout much of Millisle's existence, in particular as officers also faced severe external risks because of the Troubles. In 1979, for example, nine officers of varying ranks, a retired officer and his wife were killed by paramilitaries.[273] Some officers chose to live in staff accommodation at Millisle because it was more secure than living in the wider community, where they and their families were subject to the threat of a 'home visit'. Of the officers who gave evidence, MZ 1 had a bomb placed under his car when working in another prison and his family had to move house a dozen times,[274] while LN 20's car was hit by gunfire in an ambush as he left work.[275] Prison officers at Millisle were well aware that some of the trainees would have had close links to paramilitaries, and that there was personal danger in upsetting them.

271 Day 179, p.33.
272 Day 180, p.57.
273 MIL 567.
274 Day 181, p.6.
275 Day 181, p. 60.

173 It is against this background that the management of allegations against individual officers has to be considered. There were several mechanisms which could be used - a petition to the Northern Ireland Office, a request to speak confidentially to a Visiting Committee member, or an approach to the governor, doctor or chaplain. The evidence shows that the pressures placed on trainees rendered all these mechanisms ineffective in dealing with serious allegations of abuse by officers. Even when senior officers were approached, trainees' complaints were usually dismissed.

174 The collusion of officers in concealing abuse and poor practice was contrary to the standards which the governors promulgated and would in normal circumstances have been quite unacceptable. Taking into account the external pressures at that time it is unsurprising that officers behaved in this way, but that does not detract from the justification of the allegations made by former trainees. **The Prison Service complaints system whereby trainees could address complaints to the governor, the Visiting Committee or the Department was undermined by the pressures exerted by prison officers and rendered largely ineffective, and we consider this to have been a systemic failure.**

(e) Allegation of sexual abuse

175 HIA 248 said that ML 2, one of the nightwatchmen, befriended him, providing him with cough sweets. On a couple of occasions ML 2 put his hands under HIA 248's bedding and started to feel his private area, which left HIA 248 feeling "very uncomfortable and afraid". His bed was in the corner of the dormitory and could not be seen easily by other boys.[276]

176 This is the only instance of sexual abuse other than those concerning Officer Skillen. The nightwatchman was also the only member of staff against whom allegations have been made who was not an officer. He has not been identified.[277] His misconduct appears to have been an isolated event; it was not reported and would not have been known to other staff; it cannot therefore be considered systemic abuse.

177 William Edmonds was a Prison Officer who joined the service in November 1975. He undertook specialist training and was appointed Hospital Officer in May 1976. Dr Denis Elliott was Senior Prison Medical Officer at Magilligan Prison, where he came across William Edmonds and concluded that he had homosexual tendencies. When William Edmonds was placed

276 MIL 056.
277 MIL 096.

on a provisional basis at Millisle in December 1976, Dr Elliott expressed alarm as he thought William Edmonds was unsuited to work at Millisle, and he contacted his Governor, Mr Cunningham, the Chief Medical Officer (Prisons) and the Prisons Department, to voice his concern.[278] William Edmonds was confirmed in post in March 1977, and in May 1977 Dr Elliott contacted them again to reiterate his concern.[279]

178 Although his assessment later proved to be accurate, Dr Elliott had no firm evidence that William Edmonds was homosexual, but was making a judgement based on the impression which William Edmonds made on him. Nor did he have any information to suggest that William Edmonds's work was unsatisfactory, nor that he posed a sexual threat to the inmates. Dr McKeown, Principal Medical Officer at the Department of Health and Social Services (which had administrative responsibility for prison health services), contacted Mr Gerard David Thompson, a Prison Staffing Officer, to raise the issue, but in the absence of any evidence that could be put in writing, Mr Thompson pointed out that no action could be taken.[280]

179 No allegations of improper conduct were made concerning William Edmonds's time at Millisle, and he left in August 1979. William Edmonds subsequently had homosexual relations with HIA 531, who explicitly stated that William Edmonds "didn't do anything" to him while he was in Millisle.[281] William Edmonds himself later volunteered that he had committed an act of gross indecency in the surgery with HIA 531 and had twice tried to masturbate him at Millisle.[282] This was not known to his colleagues in Millisle, and we do not consider these incidents to be symptomatic of systemic abuse.

180 The Department of Justice have argued that any allegation of sexual abuse would have led to disciplinary action, and that they acted properly in the way that William Edmonds's case was handled, as there was no evidence that William Edmonds posed any threat of sexual abuse to the inmates, and in any case there were no grounds for being suspicious about a member of staff on the grounds that he was a homosexual.[283] [284] We agree that the Department of Justice acted correctly.

278 KIN 108013.
279 Day 212, p.45.
280 Day 212, p.48.
281 Day 212, p.49.
282 KIN 4028.
283 Day 212, p.55.
284 KIN 4030.

(f) Allegations of emotional abuse

181 The evidence provided by the witnesses included few examples of emotional abuse unconnected to physical or sexual abuse, but much of the alleged abuse had strong emotional overtones, such as the atmosphere of fear created by perceptions that physical abuse could be perpetrated by bullies at any time, or the humiliation associated with Officer Skillen's mock-sexual activities. Several witnesses described attempts by officers to humiliate them, such as an incident in the dining room when HIA 400 was taunted, he felt, to make him react and lose special privileges.[285] Indeed, the emotional associations of such incidents frequently had more severe and much more long-lasting impact than the immediate physical pain experienced by the victims. HIA 400 said that it was a constant struggle to face the fear caused by not knowing what would happen next.[286]

182 Although the overall aims of the borstal system were commendable in their wish to offer positive opportunities for trainees to obtain skills which would help them obtain employment, for example the introductory training in the closed section was designed to control them, to depersonalise them and to break them if necessary, by insisting on the completion of pointless tasks, and inflicting humiliation and minor violence at times to ensure compliance. This amounted to emotional abuse.

183 **The emotional impact of the training methods in the closed unit and the emotional damage associated with physical abuse constituted systemic abuse**.

(g) Conclusions concerning allegations of abuse by staff

184 Among the trainees there were many with long histories of offending, and some were capable of violence. As noted above, only one applicant had been admitted directly to Millisle with no previous experience of life in a training school or children's home. Indeed, all the other nine applicants made allegations primarily about one or more of the other establishments where they had been resident and their complaints about Millisle were often brief. Borstal officers were expected to be firm, and to be in control, and it is understandable therefore that they took measures to assert their authority. Excepting the allegations concerning Officer Skillen, almost all of the allegations were against prison officers and concerned physical

285 Day 179, p.23.
286 Day 179, p.25.

abuse resulting from measures to exercise control. There was only one allegation of sexual abuse.

185 Overall, the evidence presents a picture of an institution where some staff were highly thought of by the witnesses, most were seen as doing a reasonable job, and a small number were considered to have overstepped the mark in their methods of control, creating an unduly harsh and violent atmosphere, with random acts of unwarranted cruelty. Although a handful of staff were named by witnesses, Officer Skillen stood out, and was mentioned by six of the ten witnesses.

186 It was not necessary for staff to resort to abusive measures in order to remain in control, and there are instances in the evidence we have received in the course of the Inquiry where witnesses described conditions in borstals or prisons as firm or even harsh, but fair and not abusive.[287] LN 20 said that Governor McLaughlan was quite explicit to new staff that anyone assaulting trainees would be dismissed on the spot.[288] The slapping, punching, kicking and beating described by witnesses was unnecessary, contrary to Prison Rules and the Governor's policy, and unacceptable. In all, the evidence and the records indicate that over twenty trainees (or their families on their behalf) made allegations of physical abuse, either in the past or to this Inquiry, and they were justified in raising their complaints.

Peer Abuse

187 The records contain a reference to a trainee making an allegation of indecency against another trainee. This occurred in 1961 and was reported to the Visiting Committee as the reason for the victim's absconding. It appears that acts of a sexual nature had taken place in the dormitory which the two trainees shared and during a crowded film show. The Governor requested that the perpetrator should be removed to another establishment and expressed his regret, as he was "confident that little, or no, indecency existed at this Establishment".[289]

188 A Special Visiting Committee meeting took place on 9 September 1971 to address a further attempted indecent act against a trainee, which had taken place on 2 September. As a result, three trainees each suffered a number of penalties, including forfeiture of privileges, loss of pay and six strokes of the cane, as Committee members:

287 MIL 009.
288 Day 181, pp.77 and 78.
289 MIL 129.

> "expressed their opinion that it was the most unpleasant offence which they had been called upon to deal with...".[290]

The trainees were caned the same day, and the Governor informed the Ministry of Home Affairs.[291]

189 There were several references in the evidence of the witnesses to both physical and sexual abuse of boys by other trainees, usually by older boys. This is unsurprising in an establishment housing male adolescents and young adults, especially as they had experienced aggressive behaviour on the part of some staff and, in some cases, will have had histories of violence or sexual offending themselves.

190 HIA 416 said that intimidating behaviour was common, and that there was frequent violence between residents. He took various precautions to avoid beatings, but appears to have been in a state of constant fear. He was told that two boys wanted to kill him, but often the harassment was petty but intimidating, such as the constant messing of his bed, which got him into trouble with officers when they inspected the dormitories, resulting in him missing breakfast when he had to remake it. He felt that there was nothing he could do and no one in whom he could confide, though the man who ran his workshop offered him some protection.[292]

191 HIA 272 considered his time at Millisle as being "hell".[293] HIA 400 considered life in Millisle "a daily struggle" and wrote that he:

> "lived in fear not knowing what was going to happen to me from one day to the next".[294]

Other boys bullied HIA 248 but, though the staff turned a blind eye to it, this stopped after a while.[295]

192 HIA 272 recalled peers sexually abusing other trainees, and wrote that:

> "Millisle was rife with sexual predators at night time."[296]

He said he was "aware of people being raped when the lights were out", and heard "another inmate being forced to give oral sex to older

290 MIL 25761.
291 MIL 25763, 25764.
292 MIL 074.
293 MIL 011.
294 MIL 022.
295 MIL 56.
296 MIL 011.

inmates".[297] HIA 212 said that "other inmates would try to get into bed with you." He saw other boys being sexually abused, but he did not let anyone abuse him.[298]

193 In relation to the bullying and sexual abuse which took place at night, the nightwatchman did no more than a head count at regular intervals to ensure that no trainees were missing, checking in at a clock to demonstrate that he had done his rounds.[299] He was reported to have ignored seeing boys in bed with each other or hearing them moaning.[300]

194 The staff coverage at night was much lower than in the daytime, and the nightwatchmen were untrained civilians, rather than Prison Officers. **This staffing was insufficient to prevent peer abuse, and the failure to protect trainees was systemic**.

Conclusion and Summary of Findings

195 Millisle appears to have been efficiently run and it fulfilled its role in the penal system, both as an open borstal from 1956 to 1977, and from 1977 to 1980 when it had both open and closed units. It is not known how many trainees spent time at Millisle, but the existence of over a thousand 'dead' files in 1977 suggests that the total must have been around fifteen hundred. The total number of former trainees who have come forward to the Inquiry is therefore small in relation to the number who were accommodated at Millisle, and during its first twenty-two years only four applicants came forward with allegations. The primary complaints of nine of the ten applicants were about other residential establishments, and their main concern at Millisle was Officer Skillen's conduct. In short, if Officer Skillen's abuse is excluded, there were few complaints about Millisle, but that does not mean that the issues identified as systemic failures should be overlooked.

196 Millisle probably inherited a tradition of firm and tough treatment of the trainees from its predecessor at Malone and many of its staff were drafted from prisons, bringing the practices and approach to the work which they had learnt elsewhere. Trainees who avoided trouble appear to have been able to accept the spartan style of life and institutional demands for obedience and conformity. Those who did not conform, or who stood their ground, appear

297 MIL 011.
298 MIL 081.
299 Day 178, pp.17 and 55.
300 Day 180, p.41.

to have been met with rougher responses which were at times unacceptably violent, particularly in the last years before Millisle closed.

197 There were clearly witnesses who suffered from their experiences at Millisle. Looking back, HIA 416 concluded:

> "I feel like I have to reinvent myself. I did not get a good start in life and my experience as a young boy in Millisle was a brutal one. ...When I got out of borstal, I had so much anger inside me. I had become moulded into a hardened character."[301]

HIA 248 said:

> "I found this a difficult and isolating time. I never felt safe there because of the constant fear of violence. I lost all contact with my foster family. There was no-one I could talk to about my experiences. ...I was always very guarded with my emotions."[302]

HIA 272 said:

> "I just feel that if I had been treated like a human being I would have stayed and finished off my time. I was treated like an animal from day one from [when] I complained. I was not given a chance".[303]

198 In his responses concerning individual witnesses, Stephen Davis wrote on behalf of the Northern Ireland Prison Service:

> "The Department condemns without reservation any act of abuse which may have been perpetrated against any individual at Millisle Borstal. Those who were placed in that facility had every right to expect that they would be cared for with dignity and respect, treated compassionately and protected from abuse. Those who operated the Millisle Borstal facility on a day-to-day basis or who were responsible for its management, ought to have been fully aware of the high standards expected of them when caring for young people. They should have known that acts of physical, sexual or emotional abuse were unacceptable. They ought to have known that allegations of abuse, where they were raised, should have been reported to the appropriate authorities. If such abuse occurred, the Department would condemn the perpetrators of it as well as anyone who may have ignored the abuse or tolerated its occurrence." [304]

301 MIL 075.
302 MIL 056.
303 Day 178, p.51.
304 MIL 810.

199 The following are our conclusions concerning systemic abuse.

200 **We accept that there was on occasion low-level violence in the closed unit between 1977 and 1980. This was contrary to Governor McLaughlan's instructions and may have reflected working practices introduced by prison officers from other prisons in the early months of the closed section, but it was unacceptable and constituted systemic abuse. (Para. 50) It is our further conclusion that on occasion low-level physical abuse was also reported in the open borstal, and that this was also systemic abuse.**

201 **We consider Officer Skillen's behaviour to have been systemically abusive.**

202 **We also consider it a systemic failure that at times information about Officer Skillen and his misconduct failed to reach senior officers who could have taken action, and that when it did reach them, as reported in the evidence, they failed to take action.**

203 **The Prison Service complaints system whereby trainees could address complaints to the Governor, the Visiting Committee or the Department was undermined by the pressures exerted by prison officers and rendered largely ineffective, and we consider this to have been a systemic failure.**

204 **The emotional impact of the training methods in the closed unit and the emotional damage associated with physical abuse constituted systemic abuse.**

205 **The night staffing was insufficient to prevent peer abuse, and the failure to protect trainees was systemic.**

Chapter 18:

Module 11 – St Joseph's Training School, Middletown

Introduction

1 In Module 11 we considered evidence about St Joseph's Training School (St Joseph's) which was run by a Roman Catholic congregation, the Sisters of St Louis. Module 11 commenced on 8 February 2016 and concluded on 22 February 2016. We received evidence from sixteen former residents of the school, five of whom gave evidence in person during Module 11: HIA 203; HIA 178; HIA 161; HIA 198; and HIA 376.

2 The statements of two former residents, HIA 249 and HIA 176, were summarised and read out during Module 11 because they were unable for medical reasons to give evidence in person. We also took into account statements from three former residents of St Joseph's who wanted to tell us about their positive memories of the care they received in the school: SJM 73; SJM 74; and SJM 75.

3 Two former residents, HIA 49 (Day 9) and HIA 233 (Day 16) gave evidence in person about their time in St Joseph's during Module 1, which dealt with children's homes in Londonderry run by the Sisters of Nazareth. Four other former residents - HIA 124 (Day 96), HIA 195 (Day 101), HIA 175 (Day 100), and HIA 84 (Day 109) - gave evidence in person about their time in St Joseph's during Module 4, which dealt with children's homes in Belfast run by the Sisters of Nazareth.

4 During Module 11 we heard evidence in person from four nuns who worked in St Joseph's: SR 235, SR 234, SR 247 and Sister Canice Durkan. We considered helpful statements from SR 240 who was the Director of St Joseph's for almost thirty years from 1972 to 2000. Unfortunately SR 240 was unable for medical reasons to give evidence in person. We also considered a statement from SR 254. In addition to these statements the Sisters of St Louis provided written responses to the statements of former residents and related contemporaneous documentation.

5 A former member of lay staff of St Joseph's, SJM 4, provided a statement in response to allegations made against her and a written closing submission. SJM 56, who was HIA 176's social worker when she was in St Joseph's, provided a statement about his work with HIA 176.

6 We were assisted in developing our understanding of the establishment and operation of St Joseph's by the access we were given to extensive records relating to the school, which were maintained and retained by the Sisters of St Louis. These included daily logs, visitors' books, punishment

books, the minutes of meetings of the Board of Management and quarterly returns about the use of corporal punishment, which were submitted to the Ministry of Home Affairs (MoHA). We were also assisted by police material and civil claim papers in relation to St Joseph's.

7 The Department of Justice (DoJ) provided a general statement about St Joseph's and written responses to the statements provided by former residents. However, it was unable to provide detailed responses to the statements of applicant witnesses born before 1957 as its records for residents of St Joseph's only extend back to those born after that year. The Department of Health, Social Services and Public Safety (DHSSPS) provided witness statements about the inspection and regulation of St Joseph's.

8 The Health and Social Care Board (HSCB) provided a general statement about St Joseph's and written responses and background documentation about the involvement that any of its predecessor bodies had in the care of applicant witnesses.

9 The Sisters of St Louis, the DoJ, HSCB and the DHSSPS also provided written closing submissions. We are grateful for the evidence all witnesses provided for this module and the assistance it gave us in considering whether there were systemic failings in the care provided in St. Joseph's.

The Sisters of St Louis

10 The origins of the Sisters of St Louis can be traced back to 1797 in Turkenstein, near Strasbourg, when Abbé Louis Joseph Colmar, Marie Madeline Louise Humann, and Thérèse Brek signed a spiritual act of union. In 1842, a priest named Louis Bautain, influenced by the trio's spiritual path, officially founded the Institute of St Louis, in Juilly outside Paris, to promote Christian education for young people. The Institute of men and women was approved by the Vatican in July 1844, but by 1850 the priests disbanded, leaving the sisters remaining in the order.

11 In 1859, Mother Genevieve led the first group of sisters to Ireland. The sisters came to Ireland at the request of the Bishop of Clogher to open a reformatory in Monaghan town to care for deprived children. Two years later, the Irish foundation separated from the French Institute on the Bishop's orders, as he did not wish it to continue to be governed from France.

12 For the next nine decades the Irish and French Institutes expanded separately across Ireland and France. In 1903, the first Belgian foundation was established by the French Institute, and in 1912, the first English foundation was established from Ireland. However, by the end of the Second World War numbers in the French Institute had declined significantly, and in 1952 it amalgamated with the St Louis Institute in Ireland.

Establishment of St Joseph's

13 The Sisters of St Louis came to Middletown, County Armagh, in 1875. The foundation of St Joseph's was laid in 1876 at a site approximately ten miles south-west of Armagh city on the fringe of the village of Middletown. A convent and an industrial school/orphanage were opened on 25 June 1881. St Joseph's was the second industrial school to be opened in Ireland and its operation and management was governed by the Industrial Schools (Ireland) Act 1868 and subsequently the Children and Young Persons Act 1908.

14 Eight girls were admitted to the school on the day it opened and came from as far apart as Dublin, Belfast and Donegal. The admission records for the first group of children described most of them as "destitute orphans found begging", and many were as young as four years of age.[1]

15 Over the next 50 years there was extensive development of the site with the establishment of a private boarding school and a primary school. With the partition of Ireland, admissions of children from the Republic of Ireland virtually ceased. In 1942 the Sisters of St Louis decided to close the boarding school and concentrate their efforts on the industrial school/orphanage.

16 In 1950 the MoHA invited St Joseph's to become a training school, within the terms of the Children and Young Person's Act (Northern Ireland) 1950. This invitation was accepted and the industrial school/orphanage was closed, although, the children who were resident in it at that time remained in St Joseph's until they reached adulthood or were discharged. Two of these former residents, HIA 249 and HIA 178, gave evidence to the Inquiry.

1 LSN 266.

Governance of St Joseph's

17 St Joseph's was established as a training school under the terms of the Children and Young Persons Act (Northern Ireland) 1950 and the associated Training School Rules (Northern Ireland) 1952 and subsequently the Children and Young Persons Act (Northern Ireland) 1968. In 1950, the trustees of St Joseph's who were members of the Congregation of St Louis and the Archbishop of Armagh entered into a Deed of Trust with the MoHA. This Deed of Trust formed the basis of the governance arrangements for the school.[2]

18 Registration as a training school was subject to a number of conditions including the establishment of a Board of Management.[3] The Board of Management established for St Joseph's included representatives of the Trustees of St Joseph's, members of the Congregation of St Louis and local clergy appointed by the Archbishop of Armagh in his capacity as trustee.[4] While the Board of Management had responsibility for maintaining, managing and controlling the school it was answerable to the trustees of St Joseph's.

19 The other conditions of registration were that no children would be admitted to the school on a voluntary basis and the school would not refuse to take a child placed there by a court order. Since St Joseph's was meeting a statutory need the MoHA agreed to meet 100% of the revenue expenditure for the school.[5]

20 It is clear from contemporaneous correspondence that by September 1964 officials in the MoHA were becoming concerned about the operation of the school and the lack of oversight by the Board of Management. Officials raised these concerns with Cardinal Conway, the then Archbishop of Armagh, at a meeting with him in September 1964 to discuss various matters relating to the care of deprived children. Mr Parkes, of the MoHA, reiterated these concerns in writing to Cardinal Conway in a letter dated 15 November 1965. He wrote, that despite the devoted efforts of it staff, St Joseph's was:

> "…tending rather to lag behind current developments in the Training School service"

2 SJM 22717.
3 SJM 26372.
4 SJM 22718.
5 SJM 26372.

and that officials were having:

> "...difficulty in persuading the Manager [who was then SR 237] to be a little more progressive and adventurous in outlook."[6]

21 Mr Parkes also pointed out that since the school was funded entirely from public funds it was required by law to be under the control of a Board of Management, which, in addition to controlling the general policy of the school, should take a personal interest in many aspects of the welfare of the girls. He stated that in practice officials found:

> "...that the Board has played virtually no part in any aspect in the life of the school."[7]

22 Mr Parkes explained that he was approaching the cardinal for his assistance because the Board of Management of St Joseph's was seeking funding for recreation and classroom accommodation, which the MoHA was reluctant to provide without a complete reappraisal of the operation of the school. He indicated that a further consideration for the MoHA was that it had recently received a tentative proposal from the Good Shepherd Order to establish a training school for girls in Belfast. In relation to this development, Mr Parkes explained that officials were keen to have the Church's view on this matter as the Ministry was not well placed to take a decision should the need arise:

> "...which may involve a choice between the possibly conflicting claims of the St. Louis and Good Shepherd Orders."[8]

23 Cardinal Conway responded by letter on 27 November 1965[9] and suggested a meeting with officials in December 1965. However, it is clear from a further letter from Mr Parkes to the cardinal in May 1966 that for some reason the proposed meeting in December 1965 did not go ahead.

24 In this subsequent letter of 4 May 1966, Mr Parkes reiterated officials' concerns about the operation of St Joseph's and explained that following a meeting the previous week with the Reverend Mother of Middletown convent, the secretary of the Board of Management and the director of the school SR 237, officials were minded to consider immediate funding of temporary additional accommodation on the clear understanding that a

6 SJM 28224.
7 SJM 28224.
8 SJM 28224.
9 SJM 28226.

complete re-assessment would be made of the method of caring for the girls in St Joseph's.[10]

25 Mr Parkes concluded his letter by raising again the suggestion from the Good Shepherd Order that it should provide training school facilities in Belfast. He reaffirmed that the views of the Catholic Church would be of paramount importance in determining the provision of training school accommodation for Catholic girls in Northern Ireland.[11]

26 Cardinal Conway responded in writing on 18 May 1966. He confirmed he had discussions with the Mother General of the Order of St Louis and had agreed to assist in providing "new blood" for the Board of Management of St Joseph's and that the refreshed Board would be tasked to undertake a reappraisal of the methods used in the school. He indicated that this reappraisal would be informed by consideration of the operation of similar establishments in other parts of the United Kingdom. Cardinal Conway also confirmed that the Mother General had agreed that two members of St Joseph's staff would be released for relevant professional training in 1968, two in 1969 and one or two in 1970.[12]

27 These undertakings were sufficient to reassure the MoHA and it agreed to invest capital funding in the renovation and extension of facilities in St Joseph's. It also agreed to fund the establishment and operation of a pre-release/after care unit in Belfast linked to St Joseph's and run by the Sisters of St Louis.

28 However, the MoHA decided that some safeguards were required in order to justify the 100% public funding of capital expenditure by a voluntary organisation. Consequently in May 1972 an indenture between the Board of Management and its successor or successors and the MoHA was drawn up.[13] This indenture included the safeguards that the property would be vested and that the trustees would undertake to manage the school and in the event of mismanagement or a withdrawal from the work the trustees would repay all monies granted.[14] The Government for its part undertook to maintain St Joseph's as a training school and not to change its use or role arbitrarily.[15]

10 SJM 28227.
11 SJM 28228.
12 SJM 28229.
13 SJM 22741
14 SJM 26373
15 SJM 26374

29 In relation to the MoHA's concerns about the Board of Management's lack of involvement in the school, Sister Canice Durkan confirmed on behalf of the Sisters of St Louis that from the mid-1960s, the Board played a more active role in the management of the school.[16] We noted from the minutes of meetings of the Board of Management that from that time it met at least quarterly and its sub-committees, which dealt with matters such as staffing, finance and licensing of girls, met more regularly. It was also clear from the minutes that the Board of Management contributed to the development of policy for the care of the girls and the handling of disciplinary matters.

Development of St Joseph's

30 One of the first members of St Joseph's staff sent on professional qualifying training as a result of the interventions by the MoHA and Cardinal Conway was SR 240 who had commenced working in St Joseph's in 1967. SR 240 completed a Diploma in Social Work in Leicester University in 1968 and returned to St Joseph's where she was appointed deputy director in 1969 and then promoted to the role of director in 1972. She remained as director for almost thirty years until the school closed in 2000 and it is clear from the evidence we have heard that she played a major role in modernising the school and developing a child-centred ethos that underpinned all areas of its operation.

31 An early example of the impact SR 240 had on the development of the school was the successful negotiations she initiated with the MoHA about how the school should be renovated and extended. Prior to the renovations the living, school and administrative accommodation for the training school were housed in one building. The sleeping facilities consisted of three dormitories, each accommodating eleven or twelve girls. Girls were allocated to the dormitories which were designated for senior, intermediate and junior girls according to their age. The Sisters of St Louis told us that the MoHA proposed that one block should be built to replace this accommodation and should include a large central kitchen and communal bathroom facilities but that SR 240 successfully insisted that four smaller house units should be built, to mirror, as far as possible, a family home.[17]

16 SJM 22718.
17 SJM 30107.

32 These units were built in two blocks. Each block contained two units which were linked together by a connecting corridor at ground and first floor levels. Each unit was self-contained and consisted of single bedrooms, bathrooms, a kitchen and a living room. The original training school building was adapted to become the main school building and administrative block.

33 The units were called La Sallette, Lourdes, Fatima and Banneux[18] but became known by staff and girls as Houses 1, 2, 3 and 4 and that is how we will refer to them in this report. House 1 was a reception, assessment and short-term unit. Houses 2, 3 and 4 were long-term units.[19] SR 235 told us that the houses had different cultures and regimes. Girls who were assessed as needing a more regimented approach were allocated to House 2, while a more relaxed approach was adopted in House 3 and House 4 and girls were given more freedom in those houses. Each house usually accommodated up to eight girls, but when emergency admissions were required they could accommodate ten girls.

34 In the early 1970s additional staff accommodation, a swimming pool, a games hall and a modern bungalow were added. The bungalow was used as an Independence Training Unit, to assist girls to prepare for life after care. It supplemented the existing after-care facilities run by the congregation in Belfast, which were housed on the Upper Falls Road and then moved to the Glen Road. The Sisters of St Louis told us that the after-care facilities in Belfast benefitted from a support network of befriending families, voluntary workers, as well as collaboration with voluntary agencies and women's groups. They also benefitted from the services of SJM 44 who from the early 1950s to 1985 acted in a semi-voluntary capacity to assist in arranging jobs and accommodation for girls leaving St Joseph's.

35 The facilities in the school were further extended in August 1988 when the Training Schools Branch of the Northern Ireland Office (NIO) approved a proposal submitted by SR 240 on behalf of the Board of Management of St Joseph's for an Intensive Care Unit (ICU) to be built on the site. SR 240 explained in the proposal that the Board of Management envisaged the ICU being used as:

> "…a temporary respite for a girl or girls who may be emotionally disturbed, suicidal or need space in a confidential setting to express grief, anger etc."[20]

18 SJM 1511.
19 LSN 300-301.
20 SJM 1586.

36 The ICU was built alongside the Independent Training Unit and was connected to it by a corridor. It was designed to accommodate two girls at any one time and staff supervising them. It was 100% funded by the NIO and built in accordance with its blueprint. We will consider evidence about the use of the ICU later in this chapter.

37 In addition to the extension of physical facilities in the school, there were also increases in staffing levels from 1972 onwards, with the appointment of more lay members of staff, and the qualification profile of staff also improved. These improvements were also achieved through SR 240's negotiations with the NIO. SR 234 told us that when she was reviewing St Joseph's records to assist the Inquiry she found letters that SR 240 had sent to successive government departments explaining that because of the increasingly complex emotional needs and behavioural problems of girls, for example self-harming, additional staff and/or staff training were required. She confirmed that the NIO provided necessary funding in response to these requests.[21]

38 With the introduction of the Children's Order in 1995 St Joseph's became known as the St Joseph's Adolescent Centre and it was reorganised to create separate units for girls subject to care and juvenile justice orders. This arrangement continued until St Joseph's closed in 2000. The Sisters of St Louis told us that the decision was taken to close the school because of the complexities of implementing the changes required by the Children's Order 1995 and also the age profile of the sisters managing St Joseph's was increasing and there were no appropriately qualified sisters available to replace them.[22]

Admission of girls to St Joseph's

39 Approximately 1,500 girls were admitted to St Joseph's between the years 1922 and 1995.[23] In the 1950s and 1960s the number of admissions varied between four and thirteen per annum. During the 1970s this number increased and by the 1980s the average number of admissions per year was twenty.[24] Even given this increase, the level of annual admissions to St Joseph's was significantly lower than that experienced in many of the children's homes we have considered.

21 Day 186, p.66.
22 SJM 28263.
23 SJM 22715.
24 SJM 2301.

40 SR 234 told us that it was only occasionally that a girl was admitted directly to the school through a training school order issued by the Juvenile Court as a result of her offending behaviour. She explained that most girls were referred to St Joseph's because their parents or the children's homes they were placed in could not deal with their behaviour.[25] This is borne out by the admission statistics recorded in inspection reports. For example, at the time of the 1987 inspection of the school there were 32 girls on the roll and only one of them was described as a juvenile offender. Sixteen of these girls had come from children's homes. At the time of the 1994 inspection there were 32 girls on the roll; 27 had been placed in the school for care, protection and control reasons and four because of non-school attendance. Eighteen of the girls had previously been resident in one of seven children's homes located across the province.[26]

41 The majority of girls were admitted on a Place of Safety Order for a five week assessment period. The five week assessment period could be extended twice before a girl was either discharged, or a formal training school order was obtained.

42 SR 234 explained that some girls with very complex behavioural problems were sent to St Joseph's as a last resort and, to assist staff with their care, psychologists from the Adolescent Psychology and Research Unit (APRU) maintained regular contact with the school and assessed and worked with these girls. Although SR 234 appreciated this assistance, she commented that if a small psychiatric unit had been available some girls might have been more appropriately assisted in it. Her memory was that there was a small adolescent psychiatric unit in Belfast but that it was always over-subscribed.[27]

Regulation and Inspection of St Joseph's

43 The Children Act 1908 imposed a duty on the MoHA to inspect certified reformatory and industrial schools at least once a year. Industrial schools were required to maintain a record of their use of corporal punishment and as part of the inspection process inspectors checked and signed and dated these records. The dated signatures of inspectors in the punishment records maintained by St Joseph's show that the school was inspected at

25 Day 185, p.6.
26 SJM 2299.
27 Day 186, pp.58 to 59.

least annually from 1922 to 1954.[28] The inspection reports for this period record a high level of satisfaction with the condition of the children in the school and the care they were receiving.

44 An early example of such an inspection was that carried out by Mr J McCloy on 13 December 1926. He reported that on the date he visited there were:

> "…43 girls present namely, 40 under detention – of whom 5 were under six years of age – and three who had been admitted pending committal."

45 He recorded that the children appeared to be nourished, were comfortably and neatly clothed, and apparently contented and diligent. He noted that the conduct of the children had been good and that breaches of discipline had been few and the punishments mild.[29] Mr McCloy continued to be impressed with the school when he inspected it during the 1930s. In the report of his inspection in 1931 he recorded:

> "The school continues to be conducted with the usual excellence."[30]

and in the report of his 1933 inspection he recorded:

> "The children continue to be very well cared for in all respects."[31]

46 Assistant Inspector Weir inspected the school in October 1944 and reported that the general atmosphere of the home was one which merited praise and that the staff were doing excellent work.[32] Miss Florence Harrison inspected the school in December 1947. She described the sister in charge and her staff as entirely devoted to the children in their care and noted the happy relations that existed between staff and pupils.[33] Mr Weir inspected the school again in January 1949 and commented favourably on the guidance and care the children were receiving.[34]

47 The Children and Young Persons Act (Northern Ireland) 1950, provided for a power rather than a duty upon the MoHA (and subsequently the NIO) to inspect training schools. The annual inspections continued following the passing of that legislation. For example, Dr Simpson and Miss Forrest

28 SJM 29276.
29 SJM 1488.
30 SJM 1444.
31 SJM 1434.
32 SJM 1379-1380.
33 SJM 1331.
34 SJM 1329.

inspected the school in November 1951 and concluded:

> "The usual happy atmosphere prevailed with everyone going about their tasks cheerfully and quietly. ...The attitude of the staff to the girls shows itself too in the way they speak to them, affectionate, concerned and understanding."[35]

48 There was evidence in contemporaneous documentation of the school responding to matters raised by inspectors, for example providing an update to the MoHA in April 1952 about the progress achieved in completion of repairs and improvements to the home identified as necessary in the report of the inspection carried out in March 1952.[36]

49 It was also apparent from contemporaneous documentation that the inspectors' contact with the school was not limited to annual visits. For example, in 1950, Miss Forrest visited the girls during their summer holiday in Glenariff[37] and in November 1951 Dr Simpson and Miss Forrest visited a girl boarded out from St Joseph's and found she was being well cared for.[38] In the report of the inspection completed in December 1952 there was a reference to Miss Forrest being impressed by the percussion band which she had heard on an earlier visit to the school.[39]

50 Records retained by St Joseph's, including a visitor's book, daily diary, minute book and punishment book, show that MoHA inspectors visited the school on an annual basis from 1955 to 1968, with the exception of 1961.[40] While not all of these contacts were described in the documentation as inspections, they do show that inspectors maintained regular contact with the school. We also noted that HIA 249 who was resident in the school from 1946 to 1958, HIA 178 who was resident in the school from 1949 to 1964, and HIA 203 who was resident in the school from 1964 to 1967[41] all referred in their evidence to inspectors visiting the school.

51 The DHSSPS also pointed us to references in the school's records to contact between the school and Miss Forrest and other MoHA officials from 1971 to 1973 about plans for proposed new buildings.

35 SJM 1300.
36 SJM 1288.
37 SJM 1302.
38 SJM 1299.
39 SJM 1281.
40 SJM 29277.
41 SJM 071, Day 184, p.83; SJM 056.

52 It is also clear, as we have considered above, that when the MoHA became concerned about the operation of the school and the need for an updated approach it took steps to ensure these concerns were addressed.

53 The frequency and format of inspections changed with the establishment of the Department of Health and Social Services (DHSS) and the Social Work Advisory Group (SWAG) in 1972. Dr McCoy told us in Module 7, which dealt with juvenile justice institutions, that the approach taken to inspection of training schools at that time was probably similar to that which applied to voluntary children's homes and that visits would have been informal and infrequent and did not result in the production of detailed reports.[42]

54 A more consistent approach to the regulation and monitoring of training schools was re-established in 1975-76 when as a result of a major reorganisation in SWAG, an inspector, Wesley Donnell, was seconded to the NIO to provide professional social work advice about criminal justice matters including training schools.[43] Mr Donnell told us during Module 7, that as part of this role he visited training schools approximately once a month. He accepted that these visits could not be considered formal inspections but explained that they enabled him to provide professional assistance to the schools and to promote staff training.[44]

55 Sister Canice Durkan confirmed when she gave evidence in person that Mr Donnell visited St Joseph's regularly and that some of these visits were unannounced.[45] Contemporaneous documentation recorded that Mr Donnell's involvement extended to contributing to discussions about the care of individual girls. For example, the policy underpinning the operation of the ICU in St Joseph's included a requirement that where it was envisaged a girl would be kept in the unit for more than 24 hours Mr Donnell would be immediately informed and invited to attend a multi-disciplinary meeting in relation to the placement.[46]

56 We also heard evidence in Module 7 that senior personnel from the NIO's Training Schools Branch maintained regular contact with the training schools and met regularly with staff and representatives from the management boards to discuss policy and administrative matters. We

42 SPT 2000.
43 SPT 3004.
44 SPT 3005.
45 Day 187, p.149.
46 SJM 3530.

accept that officials maintained regular contact with St Joseph's and that the regular visits by Mr Donnell from 1976 onwards would have enabled significant problems in the operation of the school and the care provided to the girls to be identified and addressed. However, a more regular programme of formal inspections did not commence until 1987.

57 **We considered the lack of formal inspections in the period from 1968 to 1987 was a systemic failing by the MoHA, and then the NIO, to ensure that St Joseph's was providing proper care and meeting statutory requirements about the operation of training schools.**

Regulation of St Joseph's from 1987 onwards

58 The more regular programme of formal inspections of St Joseph's which commenced in 1987 was undertaken on behalf of the NIO by the DHSS's newly formed Social Services Inspectorate (SSI). The programme consisted of in-depth general inspections, which were undertaken in 1987 and 1993 and involved three inspectors spending a number of days in the school, and regulatory inspections, which were completed in 1992 and 1994 and involved one inspector reporting on how the school was meeting specific aspects of the Training School Rules. The SSI produced detailed reports of these inspections which provided us with helpful information about how the school operated from 1987 to 1995 and the inspectors' assessments of the quality of the care being provided to the girls during that period.

59 The first general inspection of the school was undertaken by the SSI in May 1987. Three inspectors spent a total of 101 hours inspecting the school.[47] The inspectors were positive about the standard of care the girls were receiving and recorded that it emerged through conversations with the girls that they had a high regard for staff, were generally content with the treatment they received in the school and had no complaints.[48]

60 The inspectors spent time in the school at all times of the day and at the weekends and the report of their inspection provided helpful detail about the daily living regime in the school. They described how the girls were woken around 8.15am on weekdays and were expected to wash, have breakfast and complete some chores before attending Assembly in the school at 9.30am. School continued until 4.00pm with a fifteen minute break in the morning and a lunch hour. After school, optional evening

47 SJM 1495.
48 SJM 22748.

activities were organised and an evening meal and supper were provided. The girls were free to associate with each other and bed-time was around 10.00pm. The inspectors observed that weekend days were more relaxed and unstructured with the girls being allowed to stay up late to watch television on Friday evenings and have a lie-in on Saturday mornings. They recorded that some girls were allowed home for the weekend and that those who remained undertook cleaning chores on Saturday morning and then had leisure activities including organised outings for the rest of the time.[49]

61 Staff were seen to be striving to maintain a facilitating ethos in House 1 by creating an environment of warmth, openness, trust and acceptance.[50] Nurturing of girls and the setting of limits was observed within the three long-stay houses.[51]

62 The inspectors noted that some girls because of their prior experiences could be volatile and that emotional outbursts could lead to physical confrontations, but that these were handled calmly by the staff. In general the inspectors found the environment and daily life in St Joseph's to be child-centred and commented that the staff were always available, supportive and involved in the lives of the girls.[52] They found that the concepts set out in the school's philosophy document about the provision of openness, warmth, acceptance, a non-judgemental attitude and movement at the girl's pace, were all evident in practice. The relationship between staff and girls was described as honest, trusting and supportive, and controlling as and when necessary.[53]

63 The inspectors detailed the staffing which comprised of a director, an assistant director, deputy assistant director, senior assistant, five senior residential social workers, nineteen residential social workers, one senior field social worker and one part time nurse/residential social worker. Care staff worked a 39-hour week under a split shift rota and a member of staff slept in each house unit at night. The inspectors recorded that in addition to care staff there were four teachers, administrative officers, a cook, a caretaker, a swimming pool attendant and a part-time domestic member of staff and that the services of a local medical officer and nurse were available to the school.

49 SJM 22760.
50 SJM 22764.
51 SJM 22765.
52 SJM 22761.
53 SJM 22773.

64 The inspectors noted the very low turnover of staff, the willingness of staff to be flexible about covering shifts and in particular the availability of the nuns who worked in the school. However, having regard to recommended staffing levels set out in Castle Priory guidelines, inspectors concluded that in order to maintain an acceptable level of staffing during the working day the appointment of two further residential social workers was required.[54]

65 By the time of the 1992 regulatory inspection there were 31 care staff,[55] an increase of one member of staff from 1987, and they were caring on the day of the inspection for 31 girls.[56] At the time of the general inspection in 1993 there were 33 care staff in total[57] and on the day of the census that took place that year there were 31 girls on the roll, two of whom by prior agreement were residing in their family homes. In the report of the 1994 regulatory inspection the inspector commented positively on the level of qualification of staff and the continuing staff development and training provided to them.[58]

66 This investment in staffing was accompanied by continued investment by the NIO in the maintenance and improvement of the fabric of the school. The inspectors who undertook the 1987 general inspection noted that there were excellent recreation facilities available for the girls including a swimming pool, a games hall equipped for gymnastics and a stage suitable for staging plays and concerts.[59] The inspectors who undertook the 1993 general inspection commented on the extension of the facilities available in the school including, for example, the provision of a fully equipped hairdressing salon for training purposes. The DoJ confirmed in its closing submission that:

> "St Joseph's was regarded as generously staffed, resourced and equipped."[60]

67 The inspectors identified in 1987 that while the Training School Rules specified that Boards of Management should meet as far as practical once a month that the St Joseph's Board of Management was usually meeting quarterly. By the time of the December 1994 inspection this continued to be the case and the inspector recommended that consent was sought

54 SJM 22755.
55 SJM 2300.
56 SJM 2269.
57 SJM 2267.
58 SJM 22751.
59 SJM 22758.
60 SJM 30063..

from the NIO for the Board of Management to meet quarterly rather than at monthly intervals as specified in the Training School Rules (1952).[61] This indicated that although inspectors were satisfied that quarterly meetings of the Board of Management were sufficient they were appropriately seeking to ensure that this departure from the Training School Rules was formally approved. We also saw follow-up correspondence between the NIO and the school in relation to this and other recommendations made by inspectors.

68 Also, although inspectors were satisfied in 1987 that the duty of monthly visiting by board members was being fulfilled they recommended that brief reports of visits commenting upon the general conditions, matters of interest and concern including any complaints should be tabled at each meeting of the Board of Management. During the 1994 inspection, inspectors noted that these reports were being provided and were able to identify from them that visits were not being undertaken monthly. They recommended that care should be taken to ensure that visits did take place monthly and that board members should spend sufficient time talking to the girls and making other enquiries to satisfy themselves regarding their care and the state of the school.[62]

69 Inspectors also sought the views of girls directly as part of inspections. Mr Donnell, who conducted the regulatory inspection in 1992, reported that the girls were aware of the purpose of his visit and their right to speak to him privately but none chose to and no matters or complaints were brought to his attention.[63] In advance of the 1993 general inspection each girl was sent a confidential questionnaire to complete and post back to the inspectors. The inspectors reported that although one girl commented on how far St Joseph's was from her family home and others said they would like more cigarettes, locks on bedroom doors and more freedom to go out at night in general the feedback was positive. They reported that the girls stated they felt fairly treated and knew they could talk to staff, and in particular, senior staff, if they had a worry or concern.[64]

70 Questionnaires were also sent to the parents or guardians of the girls and 50% of them were returned. All of those who responded said they were made to feel welcome when they visited the school and could speak to

61 SJM 22828.
62 SJM 22819.
63 SJM 2156-2157.
64 SJM 2270.

their child in private.[65] Also 85% of the returned questionnaires contained complimentary remarks about the staff, the friendly atmosphere that prevailed in the school and how their daughters were being well cared for and benefitting from being in the school.[66] One parent indicated that they had registered a complaint about the school with the RUC but when the inspectors wrote to the address given for this parent to seek more information the letter was returned marked "not at this address", although the inspectors recorded that it had been indicated to them that the parent still resided at the address the letter had been sent to.[67]

71 Inspectors identified a number of features that contributed to the effective provision of care in the school including that operational policies were straightforward, unambiguous and understood by all and that all staff had a sound knowledge of the girls and a consistent approach underlined the provision of care.[68] They found that discipline was maintained within a policy of balanced reward and sanction related to behaviour and concluded:

> "The main controls are the vigilance of staff and the consistency of staff team responses to each girl and her needs."[69]

72 In general, the recommendations that the inspectors made related to the development of the school, for example the possibility of employing male staff, and administrative matters such as improving the general order of the files. The inspectors' recommendations about matters relating to the direct care of the girls were few and covered such issues as increasing the amount of money available for birthday gifts for the girls, introducing incentives to encourage non-smoking[70] and maintaining a punishment book, even though corporal punishment was no longer applied, to record the sanctions imposed on girls.[71]

73 We will now consider the complaints we received about St Joseph's, under the headings: physical abuse; sexual abuse; emotional abuse; neglect, and unacceptable practices.

65 SJM 2278
66 SJM 2279
67 SJM 2279
68 SJM 2262
69 SJM 2262
70 SJM 22795.
71 SJM 2309.

Physical Abuse

74 HIA 249 was admitted to St Joseph's in 1947 aged almost five years with her two older sisters and one younger sister; she remained in the orphanage and then the training school until 1958.

75 SR 235 responded to HIA 249's evidence on behalf of the congregation. SR 235 spent three periods in St Joseph's, the first of which was from August 1958 to October 1959. HIA 249 was discharged from the school in April 1958 so SR 235 and HIA 249 were not in the school at the same time. However, SR 235 is the only living member of the congregation that worked in St Joseph's in the 1950s and for that reason she responded to HIA 249's evidence.

76 HIA 249 told us that SR 248 who was the Director when she was admitted was a good nun but that other nuns SR 237, SR 249, SR 250 and SR 252 hit her and her sisters with long thin bamboo canes called "sally rods". She described how this caning hurt her and left red marks on her skin. She also described SR 252 hitting her across her knuckles with a ruler. HIA 249 told us that she did not think SR 248 knew how the other nuns were treating her.[72]

77 She said that SR 237 was particularly harsh[73] and described how when she was around nine years of age she and other girls were frightened by the sound of an explosion at the nearby Middletown barracks and further alarmed when an older girl told them "there is somebody coming for us" and began to pray to the devil. She told us that SR 237 responded to their distress by beating them and making them kneel on the stairs all night as a punishment.[74] SR 235 responded on behalf of the congregation and said that although SR 237 was strict she did not think she would have made a child kneel all night but accepted that if it did happen then it was inappropriate and harsh.[75]

78 HIA 249 told us that girls were not allowed to talk at meal times and would be caned with a "sally rod" if they were caught talking.[76] SR 235 did not remember children being forbidden from speaking at meal times and being punished for doing so, but stated that if that was the case she

72 SJM 068
73 SJM 069.
74 SJM 070.
75 SJM 22923.
76 SJM 069.

apologised on behalf of the congregation for the implementation of such a harsh regime.

79 HIA 249 described an occasion where she and other girls were beaten for eating food intended for the nuns but in connection to that incident she also referred to a marks system that was in use at that time:

> "We didn't get stars/marks for good behaviour for a while after that."[77]

80 HIA 249 recalled that she started menstruating when she was around thirteen years and was frightened because she was unprepared and thought she was dying. She described SR 237's reaction when she caught her washing her stained sheets and mistakenly concluded that she had wet her bed:

> "She took me upstairs to my dormitory bent me over my wire bed and beat me on my bare back and bottom with a long narrow stick. She beat me until she was tired and it was the worst beating I ever had the whole time I was there."[78]

81 HIA 249 said that after this beating SR 237 gave her sanitary towels but did not explain puberty to her. She said she was so upset after the beating she ran away but as she did not know her way home she had to return to the school where she was beaten again.[79]

82 SR 235 responded to this allegation and explained that there was no entry in the punishment book of HIA 249 being punished in 1955, the year she was thirteen, and no record of her running away. SR 235 said she would totally condemn the physical punishment described by HIA 249 but pointed out that lack of discussion about puberty mirrored what would have happened in families at that time.[80]

83 HIA 249 also described SR 237 beating her with a stick for speaking back to the Reverend Mother and making her stand in school against a wall with her hands held up for the whole school day as a further punishment for the same infringement.[81] SR 235 told us there was no record of HIA 249 being punished in this way. She explained that there were eight entries in the punishment book about HIA 249 in the years between 1947 and 1954 but that only two of the punishments recorded took the form of a

77 SJM 071.
78 SJM 069.
79 SJM 070.
80 SJM 22007.
81 SJM 069.

slap and the others involved HIA 249 being deprived of treats such as sweets.[82]

84 When SR 235 worked in St Joseph's in 1958 to 1959 SR 237 was in charge. She explained that SR 237 had a reserved manner and was seen as strict:

> "She had a bunch of keys that hung on a short chain from her waistline and you'd hear the keys when she would be coming along. So people would straighten up and behave."[83]

85 SR 235 could not respond directly to HIA 249's allegations about SR 237's behaviour towards her except to say that if she behaved in the way described she would totally condemn her actions and apologise for them.[84] She explained that corporal punishment was permissible in the 1950s and she was aware it was administered in the school from overhearing girls discuss it but she never observed it being applied. She confirmed that SR 237 had a thin bamboo rod but she did not remember her carrying it around with her and thought she kept it in her office. However, she told us that she never saw SR 237 strike a girl.[85]

86 HIA 249 told us that her younger sister SJM 27 was regularly beaten because of her closeness to SR 248 by four nuns: SR 249, SR 250, SR 251 and SR 252. SR 235 explained that the congregation was not able to identify any sister called SR 251 and that the other three sisters were dead. She explained that beatings as described were not recorded in the punishment book but if they were administered and not recorded, that should not have happened and she apologised if it did.

87 SR 235 told us that there were entries in the punishment book that record SJM 27 being punished twelve times in the seven years from 1953 to 1960, but that the recorded punishments were at most two slaps and on five of the twelve occasions the punishment was deprivation of sweets or fruit.[86] SR 235 also pointed out that on occasion these punishments were applied by SR 245 with whom SJM 27 had a close relationship. HIA 249's sister SJM 27 is dead and we are not aware of any complaints she made about the treatment she received in St Joseph's.

82 SJM 22007
83 Day 186, p.17
84 SJM 22007
85 Day 186, p.16
86 SJM 22004.

88 HIA 178 was placed in St Joseph's on 23 March 1949, aged 1 year and 2 months when the home was operating as an orphanage. She remained in the school until spring 1964. Entries in the punishment book show that from the age of five years until the age of ten years HIA 178 received punishments on eleven occasions. On four of these occasions the recorded punishments are one or two slaps while on the other seven occasions the recorded punishments are deprivation of sweets or fruit. The reasons given for punishments included being "disobedient and bold" and "troublesome". Five of the punishments were administered by SR 248 and the remaining six were administered by SR 237 when she took over as director of the school.

89 HIA 178 did not recall being punished by SR 248 who she remembered as a gentle, kind person. However, she told us that she experienced "a lot of physical and emotional abuse" from SR 237. She stated:

> "She was such a wicked woman. She hated me for some reason and blamed me if anything happened or even just for simple things like laughing. She beat me with a long narrow bamboo stick or slapped me almost every day."[87]

90 HIA 178 told us that she lived in fear of SR 237 and felt that SR 237 picked on her because she had a physical disability which meant she could not use her right hand. She described an occasion when SR 237 wrongly accused her of smoking and took her upstairs, stripped her of her clothes, bent her over an iron bed and hit her with a bamboo cane while another nun, who she thought was SR 254, held her arms. HIA 178 told us that SR 237 caned her back and legs and when she finished said to her "Go and show those stripes to whoever you like."[88] HIA 178 recalled that SR 237 may have felt guilty afterwards because she offered her some sweets which HIA 178 refused to accept.

91 SR 237 is dead but SR 254 provided a statement in which she confirmed that she worked in St Joseph's for two years from 1960 to 1962 but explained that she was part of the housekeeping staff and was not involved in the care or disciplining of the girls. She told us that she had no recollection of HIA 178 and that she did not witness or assist others to beat any child with a stick.[89]

87 SJM 333.
88 SJM 334.
89 SJM 29257

92 As referred to above, HIA 249 told us that SR 237 made her and other girls kneel all night as a punishment and HIA 178 also told us that SR 237 punished her in this way. She said that she and another girl had been playing around at bedtime and as a punishment for making noise she was made to kneel in the middle of the bedroom floor all night. She commented "we weren't even allowed to be children."[90] When HIA 178 gave evidence in person she was told that the congregation found it hard to believe that SR 237 had behaved in that manner, but she insisted that she was punished in the way she described.[91]

93 HIA 178 could recall only one occasion when a nun intervened to protect her from SR 237. She said that SR 256 who taught in the school saw SR 237 pushing her to hurry her down stairs and that she intervened and told SR 237 she was going to complain to the Reverend Mother about her behaviour. HIA 178 said that SR 237 stopped pushing her on that occasion but continued to abuse her when no one was around.[92] HIA 178 told us that she talked to no one in the school about how SR 237 was treating her because she felt it must have been obvious to everyone.

94 To support this view, she told us that in 2006-7 she met a nun SR 242 who worked in St Joseph's when she was resident in the school. She said that she asked SR 242 where SR 237 was living as she wanted to confront her about how she had treated her. She said that SR 242 put her arms round her to comfort her and said "Didn't she give you terrible beatings? Sure I never done that."[93] The congregation responded to this account and said that the meeting HIA 178 described having with SR 242 could not have happened in 2006 as SR 242 was dead by then, but they did confirm that SR 242 worked in the infirmary in St Joseph's when HIA 178 was resident in the school.

95 HIA 178 explained that she had no one external to tell about the abuse and commented that even if she had, she did not think they would have believed her because people were inclined to trust the sisters.[94]

96 We are aware from material provided by the police that another girl who was resident in the school in the 1950s complained about the treatment she received from SR 237. SJM 59 was in St Joseph's from 1954 when

90 SJM 333
91 Day 184, p.75
92 SJM 334
93 SJM 335.
94 SJM 335.

she was aged nine years until 1961 when she was aged sixteen years. SJM 59 made a statement to the police in 2004 that she was force-fed by SR 237 and physically abused and denigrated by her, and by SR 239.[95] The police did not pursue the complaint since SR 237 was dead and SR 239 had left the congregation.

97 Dr Simpson and Miss Forrest of the MoHA checked the punishment book during their inspection of the school in December 1952 and recorded:

> "The punishment book shows a very occasional record of 2 slaps or 4 slaps, but mainly punishment is by deprivation of privileges. In general the impression is one of firmness and kindness in the right proportions."[96]

We understood that in this context the reference to "slap" meant being hit with a cane rather than being hit with an open hand.

98 We reviewed the punishment book for the 1950s and also found that recorded punishments were generally deprivation of sweets or fruit and where slaps were recorded it was usually two slaps. For example, it was recorded that in October 1955 a girl was deprived of sweets for being untidy and impertinent; in November 1955 a girl was deprived of fruit for being disobedient; in December 1955 a girl was deprived of pocket money for being quarrelsome;[97] and in March 1957 a girl received two slaps for sulkiness.[98] More unusual punishments were also recorded: in January 1957, a sixteen-year-old girl had her hair cut for absconding for a second time;[99] in March 1957, two girls of sixteen years were made to apologise publicly for impertinence; and, in January 1958 as a punishment for "destruction", a girl was given one slap on the hand and made to "pay a little of the cost of the article injured."[100]

99 These recorded punishments contrast significantly with the accounts we received of physical punishment and while we do not doubt the recorded punishments we recognise that it is possible that not all punishments or the extent of them were recorded. On the basis of the evidence we received from witnesses and our consideration of the punishment books we concluded that it is probable that spontaneous reactions to bad

95 SJM 4087-4093.
96 SJM 1284.
97 SJM 2049
98 SJM 2045
99 SJM 2046
100 SJM 2043

behaviour were less likely to be recorded than children being referred to the director for corporal punishment.

100 HIA 203 was committed to St Joseph's by Belfast juvenile court in November 1964 aged sixteen years and eight months and remained there until January 1967 when she was released on license at the age of eighteen years and eleven months. She was finally discharged in February 1967, the day before her nineteenth birthday. HIA 203 told us that ten days after she was admitted to the school she absconded with three other girls and was brought back some hours later by the police. She said that she and the other girls were taken to SR 237 for punishment and that while each girl was sent in separately to SR 237's room the others were supervised by SR 241. HIA 203 said that while she was waiting she was "ranting and raving" that she was not going to be hit by SR 237 and that SR 241 responded by punching her in the eye. She said she was left with a black eye, which none of the nuns commented on, and that she also got caned on the behind by SR 237.[101]

101 In a form detailing the administration of corporal punishment which the school submitted to the MoHA it is recorded that HIA 203 was given six slaps on the hand for absconding.[102] When HIA 203 was shown this return on the day she gave evidence in person she confirmed her memory that she received six slaps on her behind rather than on her hand. The Sisters of St Louis told us that this was the only complaint it has ever received about SR 241. HIA 203 confirmed that this was the only occasion that SR 241 hit her and that she saw it as a reaction to her saying that she would not allow SR 237 to hit her.

102 There was another entry in the punishment book about HIA 203 receiving six slaps for being disobedient and defiant. HIA 203 did not remember this punishment but thought it might relate to her fighting with another girl. She told us that although some nuns were physically abusive, abuse did not happen all the time and that SR 237 was not always harsh with her; "in most cases she was pretty fair."[103] She also told us that there were some "really great nuns" in St Joseph's,[104] and particularly remembered SR 269 who taught her music as a lovely nun.[105]

101 Day 184, p.23.
102 SJM 874.
103 Day 184, p.35
104 Day 184, p.29
105 Day 184, p.31

103 HIA 161 was admitted to St Joseph's in December 1968 when she was fourteen years and discharged in March 1971 when she was almost sixteen years. She described in her written statement that when she first arrived at the school she heard a girl screaming because she was being scrubbed in a bath with a deck scrubber. SR 240 provided a response in writing to this evidence and stated that she had no recollection of nuns having to bath girls as they were all teenagers and looked after their own hygiene.[106] When HIA 161 gave evidence in person she clarified that she did not actually observe the girl being scrubbed but told us that on more than one occasion she heard girls being distressed at being scrubbed and that the scrubbing was intended as a punishment rather than assistance with washing. She gave the example of girls being found in bed together being punished in this way.[107] HIA 161 described a nun SR 238 as a "nightmare":

> "I was in her dormitory and you got slapped, beaten and punched by her regularly. There was no-one I could think of in life that I could have gone to for help, no-one who would have believed me or done anything for me."[108]

104 SR 240 responded in writing to this evidence and said she was not aware of SR 238 behaving in this way and that if she had been aware of such behaviour she would have put a stop to it. She noted that HIA 161 said she felt unable to complain but pointed out that there would have been approximately eleven other girls sleeping in the dormitory and she would have expected some of them to have complained about a nun behaving in such a manner.[109] HIA 161 responded to this when she gave evidence in person and said that all the girls would have been scared to raise a complaint about a nun.[110]

105 HIA 161 remembered SR 237 and said that she "had it in" for her and her sister because they had been resident in Nazareth House before being sent to St Joseph's and the Sisters of Nazareth had given a bad account of them to the Sisters of St Louis. When asked what she remembered about SR 237 she said:

> "It was the cane, you know, and having to stand for hours and own up to something that you didn't do. You know, you would have been called

106 SJM 883
107 Day 184, p.144
108 SJM 010
109 SJM 884.
110 Day 184, p.148.

a liar and a liar until you actually said something and owned up to it just to get out of it, but then you would get punished anyway."[111]

106 HIA 161 told us she ran away with another girl and got as far as Derry where she was put in contact with an up and coming MP. She said she told the MP about the abuse she had suffered in St Joseph's and asked for her help, which she agreed to give provided HIA 161 returned to the school. HIA 161 said that when she returned to the school she was made to write out lines as a punishment for running away and speaking negatively about the nuns. Contemporaneous records maintained by the school record HIA 161 being given the task of writing out the menu because she had made "derogatory remarks about the school."[112]

107 HIA 161 told us that although she had to return to the school she believed that it was through the MP's intervention that she was eventually allowed to leave St Joseph's and stay with a family in Portadown. However the Sisters of St Louis told us that since HIA 161 was almost sixteen years old preparations had already commenced for her discharge from the school.[113]

108 SJM 73 was admitted to St Joseph's in 1970 and remained there until 1981 so she had a short period of overlap with HIA 161. She told us that she never witnessed girls being beaten or hit but that she remembered a few occasions when girls had to be restrained because they were fighting with each other.[114] She was clear that the nuns were authority figures but stated that they were not aggressive and would have talked through issues with girls.[115]

109 SJM 74 was in St Joseph's from the early 1980s to 1985. She told us that she was not hit by the nuns and did not observe other girls being hit. She explained that the punishments she received for misbehaving were being told off, sent to her room, having her pocket money reduced or losing out on a cigarette. HIA 161 also recalled cigarettes being withheld as punishment for poor behaviour.

110 HIA 176 had four placements in St Joseph's: January 1982 to January 1983; March 1983 to August 1983; February 1984 to May 1984; and, September to October 1984.

111 Day 184, p.175.
112 SJM 24704.
113 SJM 885.
114 SJM 29260.
115 SJM 29261.

111 HIA 176's sister HIA 376 had two placements in St Joseph's: the first was from June 1983 to July 1984; and the second was from August 1984 to April 1985. So for two periods the sisters were resident in the school together.

112 When HIA 376 arrived for her first placement in St Joseph's in June 1983 her sister HIA 176 was completing her second placement in the school. Both girls were in St Joseph's together for a period of two months and then HIA 176 was discharged and returned home at the end of August 1983. However, she returned in February 1984 for her third stay in the school, which lasted until May 1984. So, for approximately five months of HIA 376's first stay in St Joseph's her sister was also resident in the school.

113 HIA 376 started her second placement in the school in August 1984 and her sister (HIA 176) arrived for her fourth stay in the school in September 1984 and was discharged home in October 1984. Therefore, the sisters were only resident in the school together for three weeks during HIA 376's second stay in St Joseph's.

114 Given the overlaps in their stays in the school and common themes in what they told us we will consider their evidence together. HIA 176 made a statement to the Inquiry but was unable for medical reasons to give evidence in person, her sister HIA 376 provided a statement and gave evidence in person.

115 HIA 176 and HIA 376 both told us that they were physically abused by a lay member of staff, SJM 4. HIA 376 told us in her statement that when she first arrived at the school SJM 4 hit her on her ear and knocked her down the corridor when she asked to see her sister HIA 176 and told her she would have it hard in the school because she was bad.[116] When HIA 376 gave evidence in person she clarified that this incident commenced when she and another girl went into the staff bedroom and found a pair of SJM 4's trousers which were big enough for both girls to fit into one of the trouser legs, which they then proceeded to do. She recalled that SJM 4 came into the room while they were doing this and "backhanded her" i.e. hit her across the ear and face.[117]

116 HIA 376 told us that this was not the only occasion that SJM 4 hit her. She said she never knew when she passed SJM 4 whether she would get hit, "the backhand came so quick", and that SJM 4 pushed and poked

116 SJM 061.
117 Day 187, p.49.

her.[118] HIA 376 also said that SJM 4 hit other girls in a similar manner and that someone would get hit by SJM 4 once or twice a day.[119]

117 HIA 176 also described physical abuse by SJM 4:

> "She would be the one who would hit you, shove you about and punish you. She was a very big woman and she flung me about a few times."[120]

118 SJM 4 worked in the school from 1972 to 1988 and she provided a statement to the Inquiry in which she denied hitting HIA 376 or telling her she would have a hard time in the school because she was bad.[121] She also provided a statement denying that she treated HIA 176 in the way she alleged and stated that she never physically assaulted any child in her care.[122]

119 SR 235 responded to HIA 376's allegations about SJM 4 on behalf of the congregation and said a member of staff striking a child in the ways described would have been totally against the school's discipline and pastoral care policies and was totally inconsistent with how she observed SJM 4 treating girls in her care.[123] SR 235 also responded to HIA 176's allegations about SJM 4 and told us that SJM 4 was a much loved member of staff and that she was particularly skilled in settling new girls.[124]

120 When SR 247 gave evidence she explained that SJM 4 was a "larger than life" character and that children might react to that at first but that she found SJM 4 to be a warm nurturing person who was very motherly to the girls and was loved by them.[125] These are the only complaints we received about SJM 4 and it does not appear that the police or the congregation received any other complaints about her physical abuse of girls.[126]

121 Both HIA 376 and HIA 176 made allegations against SR 240 who was the director of the school while they were resident there. SR 240 responded in writing to the statement of HIA 376 but submitted a medical certificate to explain why she would not be able give evidence in person.

118 Day 187, p.49.
119 Day 189, p.50.
120 SJM 472.
121 SJM 15256.
122 SJM 15255.
123 SJM 927.
124 SJM 29006.
125 Day 187, p.8.
126 Day 187, p.53.

Subsequently when she was asked to respond to HIA 176's statement, her health had deteriorated to such an extent that she provided a second medical certificate to explain why she was not in a position to provide any further statements to the Inquiry.[127] Therefore, she was not able to respond personally to HIA 176's allegations but SR 235 did so on SR 240's behalf and on behalf of the congregation.

122 HIA 376 told us SR 240 gave her "terrible beatings" and that she saw her hitting other girls:

> "She carried a large bunch of keys that she used to hit us with. She would also kick me and punch me with her knuckles and fists."[128]

123 HIA 376 also described a beating she said she received from SR 240 as a result of her behaviour when she was out on a trip with SR 235. She told us that SR 235 was driving her and other girls, including her sister HIA 176, to Monaghan and that during the journey SR 235 made her travel in the boot of the car as a punishment for misbehaviour. She told us the car was stopped at an Army checkpoint and the soldier who searched it asked why HIA 376 was in the boot but accepted SR 235's explanation that HIA 376 had been speaking too much and not listening. HIA 376 said that when she returned to the school SR 240 punched and slapped her and pulled her hair as punishment for the trouble she had caused.[129]

124 SR 235 provided a statement to the Inquiry and gave evidence in person and categorically rejected the allegation that she "dragged" HIA 376 from a car and put her in the boot. She said in her statement:

> "I find such a suggestion offensive, hurtful and quite honestly beyond belief."[130]

SR 235 confirmed this response when she gave evidence in person.[131]

125 When HIA 376 gave evidence in person, SR 235's denial was put to her but she insisted that the incident happened:

> "It did happen. I still get flashbacks of it. It did happen."[132]

126 We received no other complaints of physical abuse by SR 235. The congregation pointed out that although HIA 376 said her sister HIA 176

127 Day 187, pp.118 to 119.
128 SJM 61–SJM 62.
129 SJM 63-64.
130 SJM 940.
131 Day 186, pp.27 to 28.
132 Day 187, p.86.

was in the car when this incident was said to have happened HIA 176 made no reference to it in the statement she provided to the Inquiry.[133]

127 HIA 376 also told us that SR 240 beat her when her sister HIA 176 became pregnant, because as the older sister she should have prevented her sister becoming pregnant.[134] The Congregation pointed out in response to this evidence that HIA 176 stayed in St Joseph's for a short time after she became pregnant because her parents had reacted very negatively to her pregnancy and that she subsequently paid an overnight visit to the school with her baby. The congregation also pointed out that HIA 376 accompanied her sister and niece on that visit and during it confided to staff that she was three-months pregnant.[135]

128 When Counsel to the Inquiry asked HIA 376 why she returned willingly to somewhere she says she was so badly treated she explained that she suffered abuse at home before and after her stays in St Joseph's and that at least in St Joseph's:

> "…we were getting fed. We had a roof over our head. We were warm, we had hot water you know."[136]

129 SR 240 provided a statement in response to HIA 376's allegations, in which she absolutely denied hitting HIA 376. She explained her philosophy of care while in charge of St Joseph's:

> "…because abuse is one of the main experiences these girls had in life before they came to us, any form of physical abuse was not only wrong, but it was totally contrary and counter-productive to what we were trying to achieve."

130 She explained that her main aim was to:

> "…try and help the girls to grow and to learn to take responsibility and discover what they were good at through positive education, positive role models and positive care from staff at St Joseph's in their daily lives."[137]

131 She pointed out that that there is no record of HIA 376 complaining about how she was treated when she was at the school and that a review of the diary entries made about HIA 376 are not consistent with her being unhappy in the school.[138]

133 Day 187, p.123.
134 Day 187, pp.97 to 98.
135 SJM 987.
136 Day 187, p.100.
137 SJM 921.
138 SJM 921 -922.

132 HIA 176 also told us that SR 240 carried a large bunch of keys and that she would come up behind her and dig her knuckle in her back and ask her if she was behaving herself.[139] She described an incident where girls stole altar wine while attending a retreat in Armagh and SR 240 lined up all the girls from St Joseph's who were attending the retreat and threatened to beat them all if the girls who stole the wine did not own up. She stated that when the girls who stole the wine owned up they got a "terrible beating".[140]

133 HIA 176 also described SR 240 taking a girl, SJM 54, from a classroom to her office because the girl had stolen glue to sniff. HIA 176 told us that SR 240's office was visible from the classroom and that she saw SR 240 slap SJM 54 with her hands and heard SJM 54 screaming.[141]

134 SR 235 responding on behalf of SR 240 emphasised that she was very caring in her approach to the girls in the school and that there were no records about the alleged incident of the altar wine being stolen or SJM 54 been punished for stealing glue.[142]

135 SR 235 pointed out that contemporaneous records indicate that HIA 176 was well cared for and supported in St Joseph's. SJM 56, who was HIA 176's social worker when she was at school, provided a statement to the Inquiry in which he supported this view. He told us that he maintained regular contact with HIA 176 and received letters from her in which she made no mention of feeling threatened or compromised in St Joseph's and that he reviewed relevant files and found no reference to her expressing any such feelings.[143]

136 He explained that he considered that the staff in St Joseph's were supportive of HIA 176 and created a degree of stability which enabled her to be more reflective and realistic about her family relations.[144]

137 SR 234 also gave evidence in support of SR 240 and told us that she was a very good leader and a remarkable person. She described the impression she gained after attending her first staff meeting in the school as "this place really is run for the children."[145] She told us that she occasionally heard SR 240 raise her voice and that there was no doubt she was the boss but that she loved the children and they loved her.[146]

139 SJM 474-475.
140 SJM 475.
141 SJM 475.
142 SJM 29010.
143 SJM 29312.
144 SJM 29312.
145 Day 186, p.43.
146 Day 186, p.56.

138 SR 247 told us SR 240 was highly respected by the girls and the staff[147] and described how she would work hard to give the girls a good Christmas so as to create good memories for them.[148] She also described SR 240 as:

> "…great one for children getting something to eat when they returned from absconding."[149]

139 In relation to administration of punishment by SR 240, we noted the evidence of SJM 75 who was in St Joseph's from 1994 to 1996 and who ran away on a number of occasions with other girls and was brought back by the police. She said that on her return SR 240 would give off to her and she would lose marks and be deprived of a cigarette but that would be the extent of her punishment.[150]

140 The Inquiry has received no other complaint about SR 240's behaviour in St Joseph's and is not aware of any other complaint being made about her to another relevant body, e.g. the police.[151]

141 HIA 376 complained about the behaviour of other nuns. She told us that SR 243 would wear white gloves to inspect the dormitory in House 2 after the girls had cleaned it and if she found dust she would "wreck it (the dormitory) beat us and make us do it again."[152] The congregation pointed out that SR 243 worked in House 1, not House 2, and Counsel to the Inquiry pointed out to HIA 376 that her sister had described another nun, SR 258, wearing a white glove to check for dust. However, HIA 376 was adamant that it was SR 243 that had behaved in the way she described.

142 HIA 376 also told us that on one occasion when SR 243 was driving girls to Dundalk she stopped the minibus because girls were misbehaving and "dragged" one girl SJM 19 out of the bus by her hair and beat her although she had not been involved in the misbehaviour.[153] SJM 19 did not apply to the Inquiry and as far as the Inquiry is aware has not made any complaint to any other body about how she was treated in St Joseph's.

143 The Inquiry received no other complaints about SR 243. SR 243 is dead and SR 235 responded on behalf of the congregation to the evidence

147 Day 187, p.24.
148 Day 187, pp.9 to 11.
149 Day 187, p.5.
150 SJM 29271.
151 Day 187, p.69.
152 SJM 062.
153 SJM 065.

against her. SR 235 stated that SR 243 was the fairest and most just person she knew and she could not believe any allegation that she had beaten a girl.[154]

144 HIA 376 told us that SR 275 pulled her by the ear and slapped her if she did not clean the sink properly and this left her with a dislike of anyone touching her ears and an obsession about ensuring that her sinks are clean.[155] HIA 176 also made allegations against SR 275 who she said "dished out beatings in House 2." She said that she saw SR 275 beat a girl, SJM 50.

145 SR 275 is dead, so SR 235 responded to these allegations about her on behalf of the congregation. She explained that SJM 50 was only resident in House 1 for three weeks in 1982 and that SR 275 did not work in that house at that time. SR 235 also told us in response to the allegations from both sisters about SR 275 that from her personal experience of working alongside her she did not believe she would hit any child.[156]

146 HIA 176 alleged that another nun, SR 260, broke a brush over the back of a girl, SJM 52, because she had been told that SJM 52 and other girls had been misbehaving the night before. SR 235 responded on behalf of the congregation and told us that they have no record of any such incident and that from her personal knowledge of SR 260 she would find it hard to believe that such an incident took place.[157] As far as the Inquiry is aware, this is the only complaint made about SR 260 and we noted that SJM 52 did not apply to give evidence to the Inquiry about how she was treated in St Joseph's.

147 HIA 376 told us that SJM 1, a lay member of staff beat her and had favourites. She said SJM 1 would slap her and other girls but would also give them chores as a punishment or deprive them of tea or cigarettes.[158] We were not able to trace SJM 1 and this is the only complaint against her. We noted from contemporaneous records that HIA 376 complained to SJM 1 about two girls verbally abusing her and SJM 1 brought the three girls together and settled the matter to their mutual satisfaction.[159]

154 SJM 935.
155 SJM 062.
156 SJM 29011
157 SJM 29010
158 Day 187, p.88
159 SJM 25959

148 When HIA 376 gave evidence in person she said she realised that she was headstrong when she was in St Joseph's and that her behaviour would have been difficult to deal with but that she did not deserve all the beatings she received there.[160]

149 HIA 198 spent two periods in St Joseph's. She was almost twelve years of age when she was first admitted for assessment on 5 May 1992. This admission was considered necessary because HIA 198 was engaging in self-harm and taking overdoses and was therefore considered to be a risk to herself. HIA 198 was discharged home on 5 June 1992 but subsequently had two separate overnight stays in St Joseph's in response to her behaviour in the children's home in which she had been placed. She was then admitted to the school for a second time on 22 August 1994 and remained there until 3 November 1994.

150 When she gave evidence in person HIA 198 told us that she believed that the inadequate response by residential and field social workers to her disclosures about being sexually abused and the lack of specialist treatment to assist her to deal with that abuse led to the downward spiral in her behaviour that resulted in her being admitted to St Joseph's.[161] The HSCB pointed out in its closing submission that the contemporaneous documentation shows that significant efforts were made to keep HIA 198 within her family, to secure appropriate placements for her when that proved not to be possible and to provide ongoing support to her and her family. They also emphasised that the placement in St Joseph's was necessary because HIA 198 was putting her life at significant risk.[162]

151 HIA 198 remembered the marks system that was used in St Joseph's to encourage good behaviour and we saw a note she wrote on 4 June 1992, during her assessment period, in which she referred to losing points for the use of bad language.[163]

152 She also remembered cigarettes being withheld for poor behaviour[164] and being given to reward good behaviour, including helping nuns to find girls who had absconded.[165] SR 234 responded to this evidence on behalf of the congregation and told us that cigarettes were not used as a

160 Day 187, p.87.
161 Day 185, p.5.
162 SJM 30099.
163 SJM 195.
164 Day 185, p.10.
165 Day 185, p.16.

bargaining tool or as a reward or treat by staff if a girl who had run away was subsequently returned.[166]

153 SR 235 explained that the reward system was based on each girl receiving 100 marks on a Saturday evening. Then during the week if their behaviour was not appropriate they lost marks but they could also earn additional marks for good behaviour, which were known as "plusses". Each Saturday afternoon each girl was told how many marks she had achieved and marks were also generally allocated to each House. SR 235 explained that if a girl gained "plusses" she would be given extra pocket money but if she had lost marks she would have her pocket money reduced. She confirmed that girls purchased cigarettes with their pocket money.[167]

154 HIA 198 told us that on one occasion when she absconded she was in a nearby field and was caught by SR 247 who slapped her across her face.[168] SR 247 provided a statement and gave evidence in person. She denied that she slapped HIA 198 or hit any child at any stage in her life,[169] and said she never saw any other member of staff in St Joseph's strike or humiliate a girl.[170] She told us that her only memory of HIA 198 was that on one occasion she collected her from Craigavon hospital and HIA 198 asked her to keep money safe for her.[171] She explained that on occasion she did find girls who had absconded in the fields surrounding the school and that she would walk and talk with them and usually be able to persuade them to return to the school.[172]

155 When HIA 198 gave evidence in person she was told that SR 247 denied slapping her. HIA 198 insisted that SR 247 had slapped her across the face.[173] This is the only complaint we received about SR 247 and the Sisters of St Louis confirmed they have not received any other complaint about her.[174]

156 Given the civil unrest in the province at the time and St Joseph's' location close to the border with the Republic of Ireland it is not surprising that the nuns were concerned about the safety of girls who absconded. SR 234

166 SJM 163.
167 SJM 216.
168 SJM 034.
169 Day 187, p.16.
170 Day 187, p.11.
171 Day 187, p.15.
172 Day 187, p.14.
173 Day 185, p.14.
174 Day 185, p.16.

described how SR 240 had to liaise with the Army to ask them to stop carrying out patrols in the grounds of the school and how on one occasion the school was caught in the middle of a gun battle between the Army and the IRA.[175]

157 HIA 198 told us in her written statement that she was aware of rumours in St Joseph's that SR 240 slapped girls. However, she confirmed when she gave evidence in person that although she observed SR 240 "roaring and shouting" she was never hit by her and she never saw her physically abusing any girls.[176]

158 SJM 75 was in St Joseph's from 1994 to 1996. She told us that she did not get hit or beaten by staff in St Joseph's and did not witness other girls being treated in that way:

> "I never witnessed the Sisters slapping, beating or hitting any of the girls."[177]

159 We are satisfied from the evidence we have heard that SR 237 chastised girls at times in a manner that was not formal or controlled and which was not a reasonable response to the girls' behaviour. We consider SR 237's behaviour in this regard was a particularly significant failing because of her position as director of the school and the authority and influence that role gave her. We are also satisfied, that given the descriptions of SR 237's chastisements of girls, that not all the punishments she applied, or the extent of them, were fully and/or accurately recorded in the punishment book.

160 We recognised that during the time SR 237 was the director of St Joseph's the physical chastisement of children was more common and accepted by society in general. However, we consider it significant that SR 237's approach, which we consider extended to physical abuse of girls, contrasted sharply with that of her predecessor SR 248 and that of her successor SR 240. We received consistent accounts of SR 237 being regularly physically abusive to girls and making them kneel as a punishment. We considered this behaviour was particularly damaging because of the influence and authority she held in her position as director of the school. That position meant that girls could not appeal to a more senior member of staff about SR 237's behaviour; it also meant she provided a poor example to her

175 Day 186, p.60.
176 Day 185, p.21.
177 SJM 29271.

staff about how children should be treated. **Therefore, we found SR 237's behaviour amounted to systemic physical abuse during her period of directorship between 1957 and 1971.**

161 We also considered whether the fact that SR 237 could behave as she did suggested a lack of oversight by the Reverend Mother of the Middletown convent to whom she would have been accountable. However, we noted from HIA 178's account that SR 237 stopped pushing her when another nun threatened to report her to the Reverend Mother, which indicated to us that she was concerned to ensure that her behaviour did not come to the attention of her superior.

162 We also concluded from the evidence we have heard that there were a small number of times when some staff physically chastised girls on the spur of the moment in response to particularly disruptive or provocative behaviour. However, we consider this behaviour was one-off in nature as opposed to systemic and has to be considered within the context of the small number of allegations we received about physical abuse in the school and the evidence from witnesses who told us that while they were physically abused by staff in other institutions they were well treated in St Joseph's. We also noted that according to HIA 249's evidence, which we referred to above, as far back as the 1950s a stars/marks system was used as a means of promoting good behaviour and presumably to reduce the need to punish poor behaviour.[178]

163 We consider that the departure of SR 237, the appointment of SR 240 as the director and the increase in professionally qualified staff resulted in a more benign and child-centred regime that was focused on recognising the needs of the girls and understanding their behaviour in order to support them to manage themselves and their relationships better.

Visiting Priests

164 We received evidence from four witnesses, (HIA 249, HIA 176, HIA 178 and HIA 376) about priests slapping girls in St Joseph's. HIA 249 described a priest, SJM 28, slapping her across the face when she approached to take Communion. The Sisters of St Louis confirmed that SJM 28 said Mass at the school but pointed out that it was a public Mass and he would have been observed if he had hit HIA 249 in the way she described.[179] SJM 28

178 SJM 071.
179 SJM 22006.

is dead. We received no other complaints about him and are not aware of any complaints being made about him to any other body.

165 HIA 178 told us that a priest who visited the school occasionally, who she named as SJM 36, hit her on the head for no apparent reason. Counsel to the Inquiry asked HIA 178 if she might be mistaken about the name as there was no record of a priest of that name visiting St Joseph's but she confirmed that was the name she remembered.[180]

166 HIA 376 told us she was slapped by a visiting priest for dressing inappropriately. She said in her written statement that this occurred during Mass but accepted when giving evidence in person that it was probably during morning assembly. The Sisters of St. Louis pointed out that a priest hitting a girl in the way described would have been observed and when this was put to HIA 376 when she gave evidence in person she stated that nuns were present when it happened.[181] SR 235 told us on behalf of the congregation that it has no record of any such incident happening or of HIA 376 complaining about such an incident.[182]

167 HIA 376's sister, HIA 176, told us that a priest called SJM 49 struck a girl called SJM 50 across the face when she came to receive Communion wearing bright red lipstick.[183] The Sisters of St Louis pointed out that SJM 50 gave evidence to the Inquiry about a children's home that she was resident in but made no complaints about her time in St Joseph's.[184]

168 It is noteworthy that three witnesses each described being slapped by a different priest at public Masses or assemblies in St Joseph's and in addition one witness described another girl being slapped by a priest in a similar manner. The Sisters of St Louis told us that they have no memory of or records of such incidents or complaints being made about them. While such incidents could have occurred we do not consider the evidence sufficient to amount to a finding of systemic abuse.

Peer Abuse

169 HIA 249 described two older girls bullying her and making fun of her body but confirmed that she did not report this behaviour to the nuns for

180 Day 184, p.86.
181 Day 187, p.56.
182 SJM 930.
183 SJM 474.
184 SJM 30114.

fear that the nuns would respond by beating her.[185] HIA 161 said she experienced bullying in St Joseph's[186] and that a hospital admission she had for three days in April 1969, which was recorded in St Joseph's diary but with no reason given for the admission, was a result of being beaten up by another girl and having her nose broken.[187] When asked if nuns would intervene to stop fights, she explained that sometimes they would but sometimes they would turn a blind eye.[188]

170 HIA 376 said in her statement that when she moved from House 1 to House 2, two other girls hit her on several occasions because she did not receive full marks in the reward system and that meant the whole house did not receive a weekly treat.[189] The Congregation told us that the reward system did not work in that way and that the weekly treat which was given on Friday evenings, and consisted of crisps and lemonade and occasionally an extra cigarette, was given out regardless of the marks lost by individual girls. They also confirmed that they have checked their records and there is no note of HIA 376 complaining about being physically bullied in this way.[190] There was a record of HIA 376 complaining to staff about these girls' verbal abuse of her and that a member of staff, SJM 1, talked to the three girls together and sorted matters to HIA 376's satisfaction.[191] HIA 376 explained when she gave evidence in person that the physical abuse happened at night in the dormitory and that she did not complain to staff because she knew that would only make matters worse.[192]

171 The Inquiry was able to trace one of the girls HIA 376 referred to, SJM 8. She provided a statement in which she denied hitting HIA 376 and also stated that she was never hit by nuns or staff in St Joseph's and did not see them hit other girls.[193]

172 HIA 176 also told us that she was bullied by two other girls in St Joseph's and that although she felt able to talk to a member of staff, SJM 43, who made her feel safe she could not tell her or any staff member about the bullying because she was frightened that if the girls involved were punished they would make her life more miserable.[194]

185 SJM 070.
186 SJM 010.
187 Day 184, p.149.
188 Day 184, p.147.
189 SJM 061.
190 SJM 930.
191 SJM 25958-25959.
192 Day 187, p.64.
193 SJM 15252.
194 SJM 476.

173 HIA 233 told us about name-calling between her and other girls and SR 235 confirmed this and provided a copy of a contemporaneous explanation written by HIA 233 about a fight she was involved in that was triggered by name-calling.[195]

174 SR 235 told us that staff were vigilant about bullying, would deal with it immediately and never condoned it.[196] We noted that this was also the view of the SSI inspectors who inspected the school in 1987 and recorded observing staff intervening calmly to deal with physical confrontations between girls.[197] We also noted that when HIA 376 reported problems with other girls, staff convened the girls and addressed the behaviour with them.[198] Therefore, we reached the view that while a degree of bullying and physical confrontations might be expected in a training school for girls, staff were alert to this behaviour and intervened to stop it.

Use of the Intensive Care Unit (ICU)

175 The ICU was opened in October 1990 and when the school was inspected in 1993, inspectors found that since it opened it had been used on 31 occasions, fourteen of which were attributable to six girls. The inspectors recorded that on 26 of these occasions the ICU was used because it was decided to keep girls who had returned to the school late at night and were unsettled and/or under the influence of alcohol or drugs separate from their house group until the next morning. They identified only five occasions when a girl was removed from her house unit to the ICU because of her disruptive behaviour.[199] The report of the regulatory inspection carried out in December 1994 recorded that the use of the ICU had reduced further, as it had only been used eight times in 1994.[200]

176 In her written statement, HIA 198 told us that after she ran away a few times from St Joseph's she was placed in the ICU. She stated:

> "I only got to see one staff member for one hour a day. The remainder of the time I was locked in my bedroom."[201]

195 SJM 237.
196 SJM 290014.
197 SJM 22761.
198 SJM 25959.
199 SJM 2274.
200 SJM 2306.
201 SJM 034.

HIA 198 accepted, when she gave evidence in person and had the opportunity to consider contemporaneous records, that she was placed in the ICU to manage the risk her behaviour was presenting to herself, but she insisted that there should have been a better way to take care of her.[202] Contemporaneous records show that staff closely monitored HIA 198 when she was in ICU. She confirmed that while she was in the unit she received food, had access to the toilet and was allowed to listen to the radio and read magazines and at times watch television in the living room of the unit.[203] She remembered SR 234 being with her in the ICU and encouraging her to go to sleep.[204] However, she did not remember staff talking to her about her behaviour or why she was running away.[205]

177 We saw evidence in contemporaneous documentation of professionals communicating about how best to manage HIA 198's behaviour and expressing concern about her being contained in the ICU for an extended period. However their conclusion, which was recorded by a psychologist (Michael Barbour) from the APRU who was working with HIA 198, was that keeping her in the ICU was the only way to try and keep her safe given the "unacceptably high level of risk" she was posing to herself.[206]

178 HIA 233 was transferred to St Joseph's from Harberton House and was admitted on a Place of Safety Order. The intention was that the placement would be short term and that HIA 233 would return to Harberton House. However, during planned visits to Harberton House, including overnight stays, HIA 233's behaviour continued to be challenging and an application for her to be made subject to a Training School Order was granted on 26 January 1993. HIA 233 told us in her written statement that she was content to remain in St Joseph's because she felt safer there as there were no male members of staff or residents in the school.[207]

179 When HIA 233 gave evidence in person during Module 1 she was referred to what she said in her statement about St Joseph's and she confirmed that she had no complaints to make about her time in the school and that she had "loved it" there.[208] However, she did tell us about the time she spent in the ICU and how she was transferred to the unit.

202 Day 185, p.20.
203 Day 185, p.28.
204 Day 185, p.27.
205 Day 185, p 32 to 33.
206 SJM 199.
207 SJM 027.
208 Day 16, p.116.

180 She described the ICU, which she called the "lock up", as having four cells and that each cell had a metal bed and red doors and bars on the windows. She said she was put there many times, usually for two or three days at a time and that she would be given her usual allocation of cigarettes and water but no food. She said that time in the "lock up" was a punishment and that she would be "trailed there by her hair".[209]

181 SR 235 told us in response to this evidence that the ICU did not have cells but had three bedrooms, two for the use of girls sent there although normally only one girl would be in the unit at any one time, and one bedroom for the member of staff who was supervising the girl in the unit. She explained that the bed in each bedroom had a metal frame and was secured to the floor for the girls' safety. She confirmed that the door to the ICU was red but stated that there were no bars on the windows. She explained when she gave evidence in person that if a child wanted a particular member of staff to supervise them and be with them in the ICU that was facilitated where possible.[210]

182 SR 235 explained that she reviewed the records in relation to HIA 233 and found she had four admissions to the ICU. One of these admissions was for an overnight stay, which occurred after HIA 233 was discharged from St Joseph's and her behaviour was proving disruptive in Fort James children's home. On that occasion she was admitted at 11.03pm on 31 January 1995 and released and moved to a hostel the next day.[211]

183 SR 235 provided copies of contemporaneous records that detailed the reasons for HIA 233's other three admissions to the ICU which occurred when she was resident in St Joseph's and observation notes about her behaviour in the unit. These records showed that discussions were held with HIA 233 while she was in the ICU to help her to reflect on the disruptive behaviour that had caused her to be placed in the unit. Before she was released from her first stay in the unit in November 1993 she agreed a new contract about her behaviour[212] and during her stay in March 1994 she responded in writing to questions about what behaviour had led to her being placed in the unit and her feelings about being there.[213] The records also detail the food HIA 233 was given when she was in the ICU in March 1994 and what she chose to eat.[214]

209 SJM 026.
210 Day 186, p.54.
211 SJM 243.
212 SJM 242.
213 SJM 29179 to 29181.
214 SJM 29178.

184 We noted that although HIA 233 had only three admissions to the ICU while she was resident in St Joseph's, two of these stays were for around forty-eight hours which may explain why she remembered spending considerable amounts of time in the unit. SR 235 stated that no girl was "trailed" into the ICU by the hair and usually girls would accept that their behaviour was out of control and that they would have to go to the ICU.[215] There are contemporaneous records to indicate this was the case, for example it was recorded on 9 June 1994 that staff were concerned that HIA 233 had been sniffing substances as she was very "high" and that she agreed to spend the night in the ICU.[216] However, it was also recorded that in March 1994 physical force was required to get HIA 233 to the ICU. The circumstances were recorded by the member of staff as a "major incident" which indicates they were unusual and she described requiring assistance from a colleague:

> "…to remove her (HIA 233) physically – it was a case of dragging/pushing to the pool steps – she agreed to walk with [SJM 5] up the grass"

and that once in the ICU "HIA 233 screamed, kicked etc for over an hour."[217]

185 Therefore, there is evidence of HIA 233 being physically removed to the ICU and spending extended periods in the unit. However, there is also evidence that she was properly monitored and cared for in the ICU, provided with food and assisted to consider her behaviour.

186 SJM 75 was in St Joseph's from 1994 to 1996. She told us she was placed in the ICU on one occasion for fighting. She described the ICU as "a good place to calm down" and that a member of staff stayed with her and she was allowed access to puzzles and magazines.[218]

187 From the evidence we have considered we are satisfied that the ICU was not overused and that when girls were placed in it they were appropriately cared for and monitored. When SR 240 wrote to the NIO to propose the unit she explained that the Board of Management envisaged it being used as:

> "…a temporary respite for a girl or girls who may be emotionally disturbed, suicidal or need space in a confidential setting to express grief, anger etc."[219]

215 SJM 29137.
216 SJM 29183.
217 SJM 29176.
218 SJM 29271.
219 SJM 1586

We consider that this intention was fulfilled and that there were no systemic failings in relation to the use of the ICU in St Joseph's.

Sexual Abuse

188 We received no allegations from applicants that they were sexually abused while in St Joseph's. However we are aware from material received from the police that three former residents complained to them that they suffered sexual abuse in the school.

189 In 1998 a former resident, SJM 58 complained to the police that in the mid-1970s, SJM 4 had sexually abused her. She told the police the sexual abuse started when she was fourteen and was resident in House 1, the house SJM 4 worked in, and continued after she was transferred to House 4 until she left the school two years later. SJM 58 told the police that she thought another resident SJM 109 might also have been abused by SJM 4.[220]

190 SJM 4 was interviewed by the police and denied the allegations. She admitted buying gifts for SJM 58, and that she was a favourite of hers and known as "SJM 4's child" but said that each house parent was known to have favourites.[221] Police also contacted SJM 109 who was shocked at the allegations, denied she was ever abused by SJM 4 and said she had the utmost respect for her.[222] The Director of Public Prosecutions directed no prosecution because the evidence was insufficient to afford a reasonable prospect of conviction.[223]

191 Another complaint was brought to the attention of the police by the congregation when a former resident, SJM 60, told a nun that a male member of staff who looked after the swimming pool in St Joseph's sexually abused her.[224] The matter was not investigated by the police because once SJM 60 learned that the man in question was dead, she did not proceed with her complaint.

192 SJM 59 spoke to police in 2004 about her time in St Joseph's from 1954 aged nine years until she left in 1961. She alleged that she was sexually abused on a regular basis by SR 238.[225] Police investigations found that SR

220 SJM 4034–4040
221 SJM 4026
222 SJM 4026-4027.
223 SJM 4020.
224 SJM 4079.
225 SJM 4087-4093.

238 was still alive but suffering from senile dementia and it was determined that she could not be interviewed because of her medical condition.[226]

193 These are the only allegations of sexual abuse in St Joseph's that we are aware of and we do not find that they amount to evidence of systemic sexual abuse. We also noted that HIA 195, who told us she was abused in Nazareth House by Father Brendan Smith, felt able when he visited her in St Joseph's to tell a member of staff that he scared her. She said the member of staff told SR 240 who went out to see Father Smyth as he was leaving in his car and told him that he wasn't welcome to visit HIA 195 again.[227]

Emotional Abuse

194 HIA 178 told us that SR 237 made demeaning remarks about her mother in front of other girls:

> "She told me that I would 'end up in jail like your mother' and also that 'she didn't want you and so we had to look after you'."[228]

HIA 178 explained that she had not known until that point that her mother had been in prison.

195 HIA 178 also recalled SR 237 pulling curlers out of her hair which she had received as a present from a former day pupil at her school and confiscating a scarf she received from a former resident and telling her on both occasions: "We have no pets here."[229] She also told us that when she told SR 237 that she had passed a music examination SR 237 slapped her across the face and she thought that was to ensure that she did not get above herself.

196 HIA 203 told us that when her older sister DL 219 came to visit her in St Joseph's she was kept at the door and not allowed in. She told us that SR 237 and SR 242 said DL 219 was unholy and a fallen woman and that HIA 203 should not be associating with her. When she gave evidence in person, HIA 203 commented that she thought the nuns responded in that way because they had a funny attitude to unmarried women having children or to women who married outside the Catholic faith.[230]

226 SJM 4113.
227 SNB 176.
228 SJM 334.
229 Day 184, pp.88 to 89.
230 Day 184, p.43.

197 HIA 249 described a lack of affection from the nuns:

> "We were never shown any affection by the nuns - no love at all. They were very cruel. I remember feeling frightened of them all the time."[231]

However, she acknowledged that her sister SJM 27 had a very close relationship with SR 248. The Sisters of St Louis confirmed this and explained that in 2010 they agreed to SJM 27's request to be buried with SR 248 whom she considered to be a mother figure and that SJM 27 was the only person other than a nun to be buried in the cemetery at Middletown convent.[232]

198 HIA 376 told us that when she took an overdose in July 1983, a few weeks after her first admission to the school, she had to stay in hospital for a few days and her sister HIA 176 was not allowed to leave the school to visit her and her parents were not informed for a week. She said when she returned to the school she was not given food for three days and she believed this was a punishment for taking an overdose.[233] SR 235 responded on behalf of the congregation and explained the assessment and treatment that a girl who took an overdose would receive and stated that in her experience:

> "There would never have been punishment meted out as HIA 376 describes."[234]

She also explained that there was no record of HIA 176 asking to visit her sister.

199 HIA 376 said in her statement that SR 240 told her that her parents didn't want her and that was why she was in the home and that she was dirty.[235]

200 HIA 176 told us that when she became pregnant at sixteen it was a result of being raped by a twenty-year-old man. She said that staff in St Joseph's and her social worker SJM 56 knew the pregnancy was the result of a rape but provided no help to her.[236] Both SJM 56 and SR 235 told us that there are no references in contemporaneous records to HIA 176 telling them that the pregnancy was the result of being raped.[237]

231 SJM 069.
232 SJM 22005.
233 SJM 064.
234 SJM 939
235 SJM 062.
236 SJM 477.
237 SJM 2931-29313 and SJM 29016.

201 HIA 176 also told us that when she was pregnant SR 240 called her a whore and said she was unfit to be a mother.[238] However, SR 235 pointed out that HIA 176 was allowed to stay in St Joseph's when her pregnancy caused trouble with her parents and that after she had her child she brought her to St Joseph's for an overnight stay. SR 235 also explained that staff assisted a number of girls who became pregnant during their time in St Joseph's and that the independent living bungalow was converted to enable two girls to remain in the school with their babies.[239]

202 HIA 176 told us that SJM 4 subjected her to verbal and emotional abuse. She said that she called her a "Derry Hog" and laughed at her when she asked for a bra, saying that she would need to get a chest to get a bra.[240] SJM 4 denied that she behaved in this way and said that although some of the girls used the term "Derry Hogs" she never did.

203 We were concerned to note that when she was interviewed by the police about alleged sexual abuse SJM 4 admitted that the woman who alleged the abuse was her favourite and was known to be and that all house parents had favourites.[241]

204 When SR 235 responded to evidence from HIA 376 that a nun SR 246 favoured her and another girl, she pointed out that behaviour which favoured one girl over another would quickly have led to an enquiry by other girls:

> "They were very conscious of anything that could be perceived as favouring one girl over another."[242]

We consider this an accurate assessment of how girls would be alert to favouritism by staff and therefore we consider that the overt favouritism admitted by SJM 4, which included the girl in question being called "SJM 4's child" was poor practice and should have been identified as such and addressed by senior staff.

205 HIA 176 told us that she found the public awarding of marks for behaviour humiliating.[243] However, we accept that the public allocation of marks was used to motivate girls towards good behaviour and reinforce the consequences of poor behaviour.

238 SJM 470.
239 SJM 29016.
240 SJM 472.
241 SJM 4026.
242 SJM 941
243 SJM 473

206 HIA 233 told us that staff in St Joseph's were kind to her and she particularly remembered SR 236 singing to her to try and calm her down.[244] She recognised that she was a "handful" and she recalled SR 235 calling her a "delinquent". SR 235 told us she had no memory of this and that it was not the type of language she would have used to any of the girls.[245]

207 HIA 233 indicated that at times she felt anger towards staff in St Joseph's because they did not believe her about the sexual abuse she suffered prior to her admission to the school. SR 235 told us that staff did believe that HIA 233 had been sexually abused and referred us to the minute of a review meeting held in January 1993,[246] where the implications of the abuse for HIA 233's return home were discussed, and to handwritten notes of a discussion a member of staff had with HIA 233 about it.[247] However, the fact remains that HIA 233 felt that she was not believed about the abuse.

208 HIA 49, who was in the school from 1971 to 1974, told us she loved it there and said in her statement:

> "I'd never had a hug in my life and I got a hug off [SR 240]...They treated us like human beings and trusted us. The nuns were kind and considerate."[248]

209 When she gave evidence in person, she confirmed this experience of the school and referred in particular to her mother being invited to stay at the school so that she and HIA 49 could spend some time reconnecting with each other.[249]

210 HIA 175, who was in the school from 1972 to 1974, told us that she was happy in St Joseph's and that in particular SR 240 made her feel that she mattered:

> "You were made feel like you were wanted and were treated with warmth and affection which I had never experienced before."[250]

211 HIA 195 who was in the school from 1977 to 1979 told us:

> "I loved it in Middletown. The nuns were brilliant. The staff members were so good to us."[251]

244 SJM 026
245 SJM 215
246 SJM 215
247 SJM 239
248 SJM 22253
249 Day 9, p.31.
250 SJM 22239.
251 SNB 176.

212 We carefully considered the allegations we have heard about emotional abuse in St Joseph's, such as the derogatory remarks made by SR 237, and we noted the overt favouritism by staff described by SJM 4. We also took into account the positive accounts we have received about the warm care and attention witnesses told us they received in St Joseph's and the clear focus from the 1970s onwards on promoting the emotional well-being of the girls. We concluded from all the evidence available to us that there was not systemic emotional abuse of girls in St Joseph's.

Neglect

Medical Treatment

213 HIA 178 suffered from a disability caused by an injury at birth. Contemporaneous records and correspondence show that the congregation sought medical assistance about the disability, which entailed HIA 178 having appointments with an orthopaedic consultant in May and August 1949 and October 1950. When Dr Simpson and Miss Forrest inspected the school in December 1950, they recommended that a written diagnosis and prognosis should be requested from the surgeon.[252] This was subsequently received and the surgeon confirmed that no effective treatment was available.[253] HIA 178 accepted that she attended medical appointments but told us she had no memory of being encouraged or helped to do the exercises that the consultant had recommended.[254]

214 There is also a record of HIA 178 having a hospital stay of just under a month in August/September 1949 but it is unclear why the hospitalisation was considered necessary and what it achieved, and HIA 178 who was under two years of age at that time has understandably no memory of the reason for it. HIA 178 did remember having her head shaved for a medical appointment and she thought that might have been in relation to the treatment of ringworm.[255]

215 The congregation told us that a local doctor would visit the school fortnightly.[256] HIA 178 did not remember seeing a doctor but she did remember a dentist coming to the school.

252 SJM 22963.
253 SJM 22937.
254 SJM 337.
255 Day 184, p.85.
256 SJM 22925.

216 HIA 249 remembered being sick in bed but did not remember seeing a doctor or a nurse. However, she remembered being taken to hospital when she fell off a chair and having her arm put in plaster.[257]

217 A doctor's opinion was sought about the appropriateness of HIA 249 being in an industrial school because of her age and her fragile health. We saw a doctor's written confirmation that HIA 249 suffered from congenital heart disease and his opinion that she was being cared for particularly well in St Joseph's.[258] SR 235 confirmed on behalf of the congregation that HIA 249 was admitted to the Royal Victoria Hospital on 11 December 1955 in relation to her heart condition and remained there for nine days and that there was follow-up correspondence between the hospital and the school about her care.[259]

218 HIA 203 told us in her written statement that SR 237 did not believe her when she said she was feeling ill and that it was only through the intervention of a caretaker who noticed how swollen her jaw was that she was diagnosed as suffering from mumps. She told us in her written statement that she was left alone in the school while she was sick in bed with mumps, but clarified when she gave evidence in person that a nun brought her food although she was left mainly on her own.[260] Even though the Sisters of St Louis pointed out that there is no record of HIA 203 being sick with mumps she was definite that was the case.

219 HIA 176 remembered consulting a nurse who worked in St Joseph's and also being seen by a local doctor. She told us she complained to the nurse about problems with her chest and was told it was phlegm. She linked this lack of treatment to asthma that she suffered from as an adult. She also told us that she did not attend a dentist while she was in St Joseph's.[261]

220 SR 235 responded on behalf of the congregation and provided copies of documentation which recorded the medical attention HIA 176 received, including a referral for a chest x-ray. She also confirmed that when HIA 176 was in St Joseph's, a nurse was employed in the school to tend to the girls and that a local doctor was available to advise on more serious

257 SJM 071.
258 SJM 1333.
259 SJM 22010.
260 Day 184, p.36.
261 SJM 475.

conditions.[262] She explained that HIA 176 developed an abscess on her tooth when she was on holiday in Runkerry and that the records of that trip indicate that she developed a fear of the dentist. SR 235 notes that this may explain why HIA 176 received treatment for this abscess from the local doctor who attended the girls in St Joseph's and why she did not have the regular dental check-ups which records show the other girls attended.[263]

221 HIA 176 also said that she was unprepared for puberty and that although SR 243 had been kind to her when she got her first period she did not provide any further guidance. SR 235 explained that the girls received sex education in class, and she assumed this would have covered menstruation, and that girls would have discussed such matters with house staff. We noted that the diaries which were maintained in the houses when HIA 176 was a resident in the school recorded when girls had their periods.[264]

222 We concluded from the evidence, particularly that provided in the contemporaneous records, that nursing care was provided on site and that the girls could avail of regular consultations with a local doctor and dentist. It is also clear that when specialised medical attention was required it was arranged. We also noted that SSI inspectors were satisfied with the health care that was available to the girls and the records that were maintained of illnesses and medical complaints and the treatment given for them. In the report of the inspection that took place in 1993 the inspectors noted that satisfactory arrangements were in place for medical, nursing and dental care and that, for example, the girls received dental check-ups every six months.[265]

Education

223 HIA 178 told us that her education in St Joseph's was inadequate and described being made to sit at the back of the class and having to teach herself to read.[266] Contemporaneous records show that HIA 178 did well in typing and elocution but she said she had no memory of these achievements.[267]

262 SJM 29013.
263 SJM 29013.
264 SJM 29013.
265 SJM 1778.
266 Day 184, p.90.
267 Day 184, p.91.

224 HIA 249 also told us that she was made to sit at the back of the class and got no support to learn. She said that nuns beat her for mistakes and that day pupils from the locality who also attended the school were not beaten in the same manner.[268]

225 HIA 178 told us she had positive memories of learning to play music and Irish dancing.[269] HIA 203 was also positive about the music classes she attended and the nun who taught her, SR 269. She remembered being hit on the hands for not playing the piano correctly but recalled that it was SR 237 who hit her, not SR 269.

226 HIA 176 complained that the education at St Joseph's was poor and that some teachers allowed the girls to engage in leisure activities such as playing bingo and watching films rather than learning activities.[270] SR 235 responded on behalf of the congregation and, while unable to comment on HIA 176's comments about the behaviour of individual teachers, she did provide a copy of the annual education report for 1984-85 which showed the positive educational results achieved by the girls in that year.[271]

227 In contrast to the criticisms we received about the standard of education provided in St Joseph's, we also received positive comments from witnesses about how they were enabled to learn in the school. HIA 84, who was in St Joseph's in 1976-77, said it was one of the happiest times in her life and she appreciated the different classes available to her, including being able to learn to do tapestry.[272] Also, SJM 75, who was in the school from 1994 to 1996, told us that she had been expelled from her secondary school and that she learnt to read and write in St Joseph's as the smaller class sizes made it easier for her to learn.[273]

228 We noted that in the 1993 inspection of the school the SSI inspectors recorded that Department of Education inspectors who had inspected the school in 1989-90 had commented on the good relationship that existed between staff and girls and how it would "undoubtedly lead to the promotion of higher levels of self-esteem and self-confidence."[274] The inspectors also commented on the investment in the fabric of the school

268 SJM 071.
269 Day 184, p.78.
270 SJM 474.
271 SJM 29009.
272 SNB 726.
273 SJM 29271.
274 SJM 1773.

and how it helped to create the necessary environment within which "the young people have the opportunity to learn and develop intellectually."[275]

229 The DoJ in its closing submission referred us to the written report by a member of the Management Board who had visited the school in August 1995. As part of that visit she met with one of the teachers who informed her that education inspectors had visited recently. They had stated they were very impressed by the exam results achieved and her teaching methods and commitment and had requested that her training packages be made available to other schools.[276]

230 From the evidence we considered we reached the view that education was seen as a central element of the care provided to girls in St Joseph's and that it was well resourced in relation to the number of teaching staff and the physical environment. There is evidence that girls undertook state examinations, which provided formal recognition of their academic attainment, and throughout the decades girls were taught to play musical instruments and benefited from elocution lessons.

Enuresis

231 Since St Joseph's mainly cared for older girls from 1952 onwards we heard very little evidence about the management of enuresis. However, we considered it worth noting that HIA 124, who was in the school from approximately 1974 to 1977, told us that after being punished for her enuresis in another children's home she was too scared to tell the staff in St Joseph's about her difficulties with it. She explained that a member of staff realised her difficulty and brought her new sheets and a rubber sheet and with her agreement arranged for a member of staff to wake her early so that she could change her bed and shower before the other girls were awake. HIA 124 told us that in time she stopped wetting her bed and that with the support of SR 240 in later years she shared her experience with other girls in St Joseph's who were suffering with enuresis.[277]

232 We carefully considered the written statements, oral testimony and contemporaneous records and correspondence in relation to the care provided in St Joseph's and we did not find evidence of systemic neglect.

275 SJM 1773.
276 SJM 30047.
277 SNB 842-843.

Unacceptable Practices

Excessive Chores

233 HIA 203 was resident in the school from 1964 to 1967. She complained of having to do excessive chores and said she was constantly scrubbing floors and having to work in the laundry. She told us that as an older girl she was expected to supervise younger residents to make sure they bathed and washed their hair and that if they misbehaved SR 237 would "have a go at them and then have a go at me."[278]

234 The Sisters of St Louis pointed out in its response that since all the girls were teenagers there would have been no need for HIA 203 to supervise them, but HIA 203 insisted when she gave evidence in person that because she was the oldest girl SR 237 would shout at her if younger girls did not behave properly.[279] She also clarified that she was not saying she had to scrub floors all day but that she had more chores to complete in the mornings than the girls who attended school and she then had to work all day in the laundry that served the school.[280]

235 HIA 178 also told us that she had to do excessive chores from an early age and did not agree with the response provided by the Sisters of St Louis that chores were age appropriate and were the sort of chores children would be expected to do in a family home.

236 HIA 249 described having to clean on a daily basis from a young age and told us that on one occasion a nun beat her because she put a cloth on her foot to help wax and polish the floor.[281] SR 234 responded on behalf of the congregation and explained in her statement that attaching cloths to feet was the method used for polishing the floor and that therefore she could not understand why HIA 249 would have been punished for doing that.[282]

237 HIA 376 complained about excessive chores and said that her hands were "red raw" from cleaning.[283] She described having to clean all day Saturday and moving all the chairs and furniture from rooms into the garden in order to clean the rooms.[284] SR 235 responded on behalf of the congregation and

278 Day 184, p.14.
279 Day 184, p.14.
280 Day 184, p.16.
281 SJM 068.
282 SJM 22005.
283 SJM 062.
284 Day 187, p.90.

explained that at the time HIA 376 was in the school, although chores had to be done each day, the girls would be allowed a lie-in on Saturday mornings and after completing some chores with the assistance of staff they would have had Saturday afternoons free.[285] She pointed out that the furniture in the houses was much too heavy for it to be removed to the garden as described by HIA 376.[286] SR 235 also referred us to a description in the report of the 1987 inspection of the school of the relaxed atmosphere that prevailed on Saturdays and the outings that were arranged, and she confirmed that was her memory of Saturdays in the school at that time. She also provided a copy of a diary entry for 24 November 1984 that recorded HIA 376 having a lie-in until 1p.m. on that Saturday and referred us to other diary entries which record HIA 376 enjoying her work in the kitchen and expressing positive views about it. When HIA 376 gave evidence in person she insisted that cleaning was undertaken all day until teatime on Saturdays and that furniture had to be moved as part of that cleaning. She confirmed that she regarded the amount of cleaning she was expected to do as excessive.[287]

238 SJM 73, SJM 74 and SJM 75 provided positive statements about the care they received in St Joseph's and told us that they had chores to do, which were allocated on a weekly basis, but that they were not onerous and were the type of chores they were expected to do in their family homes.

239 In response to the evidence of witnesses about excessive chores SJM 4 told us that it was important to have an organised regime that enabled the girls to contribute to keeping the "home" tidy and a reasonable place to live and she stressed that the daily chores were light duties and that external cleaners were used for more substantial cleaning.[288]

240 We accepted that until the start of the 1970s girls had to do daily chores which often involved a significant level of manual work. However, it appeared that once the new house units opened the chores were more akin to those that would be expected in a family home. We consider this change in expectation and approach reflected the wider societal norms about how much physical work children should undertake therefore we did not consider that the chores expected of the girls amounted to systemic abuse.

285 SJM 935.
286 SJM 936.
287 Day 187, pp. 90 to 91.
288 SJM 21001.

Force Feeding

241 HIA 203 recalled being force-fed beetroot by a nun she could not name. She said the nun forced the beetroot into her mouth and as a result she vomited. She confirmed that this had only happened on one occasion. When she was told by Counsel to the Inquiry that SR 240 told us that in her long time working in the school she had never heard of an allegation of force-feeding, HIA 203 was adamant that it had happened.

242 HIA 161 also told us when she gave evidence in person that she was force-fed in St Joseph's with nuns holding her down and forcing food into her mouth.[289] The Sisters of St Louis pointed out in their closing submission that although she wrote a book about her time in care this is the first time HIA 161 had made such an allegation.[290]

243 From the evidence we have heard we do not believe that force-feeding was a regular occurrence in St Joseph's and while these incidents may have happened we do not consider they amount to systemic abuse.

Separation of Siblings

244 HIA 203 was admitted to St Joseph's with her sister and they spent time together in the school. However, she told us that on one occasion she was prevented from spending time with her two brothers, who were resident in another children's home. She explained that she saw her brothers as they were leaving the holiday house used by the Catholic congregations in Glenariff as she was arriving. She described how she and her brothers ran to each other but were pulled apart by a nun and not allowed to spend time together. She could not recall the name of the nun who pulled them apart. She also told us that she wrote letters to her brothers but that they did not receive them. The Sisters of St Louis provided documentation that showed that HIA 203 and her sister DL 222 had written to their other sister who was living in England and that correspondence had been received, but HIA 203 had no memory of writing to her sister.

245 HIA 249, who was admitted to St Joseph's with her sisters in 1946, told us that she was separated from her sisters on arrival at the school. There is no living sister who worked in the school in the 1940s, but SR 235 who worked in it in the 1950s explained that at that time and in earlier years girls were allocated to dormitories according to their age and that could

289 Day 184, p.177.
290 SJM 30112.

explain why HIA 249 was separated from her sisters. However, she pointed out that HIA 249 would have had contact with her sisters throughout the day in the classroom and at meal times.[291] We noted correspondence in 1947 between SR 248 and the MoHA about the appropriateness of HIA 249 and her baby sister residing in an industrial school. SR 248 pointed out in that correspondence that the continuance of the placement would have the advantage of enabling HIA 249 to have the companionship of her sisters.[292]

246 HIA 249 also told us that there was no privacy during family visits and that she and her sisters were taken in separately to meet their parents and that a nun was always in attendance. She suggested this may have been to prevent her older sisters from complaining about the treatment they were receiving.[293]

247 HIA 376 said that she and her sister who were in St Joseph's together for two periods amounting to five months in total from 1983 to 1985 were kept apart. SR 235 explained on behalf of the congregation that at that time its approach was to give sisters placed in the school at the same time the opportunity to develop their own identity in recognition that many of the girls had been neglected in their homes and that tensions may have existed between siblings. She explained that the decisions about whether the sisters should be accommodated in the same house would have been influenced by what was known about their relationship and she exhibited contemporaneous records which showed that tensions existed between HIA 376 and her sister HIA 176.[294] However, she pointed out that the sisters would have been in the same class in school and that there would have been no barrier to seeing each other in the evenings.[295] HIA 376 accepted when she gave evidence in person that there were opportunities during the day when she could see her sister but that when she asked to see her in the evening it would depend on the mood of the staff member on duty whether she would be allowed to do so.[296]

248 HIA 376 also recounted a time when her parents visited and she was not allowed to spend time with them and her sister but was made to serve them tea and then was taken to a small television room where

291 SJM 22003.
292 SJM 1341.
293 SJM 072.
294 SJM 928.
295 Day 187, p.95.
296 Day 187, p.96.

she observed them though a window.[297] SR 235 responded on behalf of the congregation and said that staff were not present during family visits unless there were restrictions regarding family access, so that the separation from her parents that HIA 376 described could not have been enforced and would have been "completely inconsistent with how we sought to maintain links between girls and their parents."[298] HIA 376 accepted when she gave evidence in person that most weekends she was given leave to return home and therefore had access to her parents and her sister then.[299]

249 HIA 176 told us that she only learnt from another girl that her sister HIA 376 was hospitalised as a result of taking an overdose. She said that when she asked SR 240 about it she was told to go about her own business and that her sister would be all night. She also told us that she was not allowed to visit HIA 376 in hospital. SR 235 responded on behalf of the congregation and told us that there was no record of HIA 176 asking to visit HIA 376 in hospital.[300]

250 We concluded that there was not a policy of separating siblings in St Joseph's and that even in earlier years when girls were allocated to dormitories according to their age there were still opportunities for them to socialise together during the day. We considered that although HIA 376 and HIA 176 were in different houses there were ample opportunities for them to spend time together during the day and when they were at home together at weekends. HIA 203 was obviously upset about not being allowed to spend time with her brothers when they met in Glenariff but we accepted that this approach may have been taken for the practical reason that the boys needed to leave the holiday home so that the girls could settle in. We do not consider that this one-off occurrence amounted to systemic abuse.

A False Impression Created for Inspectors

251 HIA 203 recalled new linen being put on beds when someone official was coming to visit and that when the visit was over it was removed. She also recalled being told to be careful about what she said to any such visitors.[301] HIA 203 clarified at the hearing that the usual linen was of a

297 Day 178, p.94.
298 SJM 939.
299 Day 187, p.94.
300 SJM 29007.
301 SJM 056.

good standard and regularly laundered but was adamant that new bedding was put on for official visits and then removed. When Counsel explained that SR 240 did not recall such practices in her time in St Joseph's, HIA 230 responded "well, it didn't happen maybe in her time, but it did happen in mine."[302]

252 HIA 178 remembered that although the clothes she was given to wear were second hand they were lovely. She also remembered being given better clothes when inspectors were coming, but that those clothes were taken off her when the inspectors left. When Counsel put to her the Sisters of St Louis's response that children received new clothes regularly she disagreed and was adamant that better clothes were given out for inspections and then taken back. She also commented that children were not allowed to speak privately to inspectors.[303] While we considered it possible that better linen and clothing may have been given out for use on days inspectors were expected, we do not consider that amounts to systemic abuse, particularly as the applicants told us that the standard of the regular linen and clothing was good.

Religious Observance

253 HIA 203 and HIA 376 told us that there was an excessive emphasis on religious practice and observance. HIA 203 recalled having to go to Mass every day and having to pray regularly throughout the day, but the Sisters of St Louis stated that girls were only required to go to Mass once a week and were expected to attend daily assembly. HIA 176 accepted when giving evidence in person that it would have been assembly not Mass that they were required to attend each day.[304]

254 The DoJ in its closing submission pointed out in response to this evidence that the Training School Rules provided that each day should begin and end with a prayer and that Holy Days should be observed in such a manner as the Board of Management deemed appropriate.[305]

255 Inspectors considered religious observance in their inspections in 1987, 1993 and 1994 and did not find the approach excessive. Inspectors commented in the 1993 report that while the school was strongly influenced by a religious order:

302 Day 184, p.49.
303 Day 184, p.87.
304 Day 187, p.54.
305 SJM 30044.

> "Religion does not seem to be over-emphasised in the daily life of the school."[306]

St Joseph's was run by a Roman Catholic order for girls of that faith and therefore we consider that religious observance was an understandable aspect of the life of the school and the evidence we received did not suggest that it was excessive.

Food

256 Miss Forrest inspected the school in November 1951 and observed:

> "We saw a satisfying meal being prepared in the kitchen. The appearance of the girls is the best recommendation for their diet!"[307]

This was echoed by the recorded observations of Mr Hughes, who was a monthly visitor to the home in 1956:

> "I have seen the children of this school monthly for the last 12 months and often during meal times. They are well looked after as regards food and clothing and always appeared to be very happy."[308]

257 HIA 178 told us that often she did not get enough to eat and went to bed hungry.[309] HIA 161 also said that she did not receive enough food. She told us that on one occasion she and other girls locked themselves in the refectory and handed over a list of demands to be met before they would come out, including a demand for more bread and butter.[310] She explained that the lock-in came to an end because some of the girls needed to go to the toilet and that their demands were not met.[311]

258 While we accept that access to food is an emotional issue and that there may have been occasions when growing girls felt hungry we found no evidence of systemic abuse in relation to the provision of food in St Joseph's.

Smoking

259 HIA 176 criticised the congregation for facilitating smoking amongst the girls[312] and indicated that she started smoking in St Joseph's. However

306 SJM 1769.
307 SJM 1300.
308 SJM 25261.
309 SJM 337.
310 Day 184, p.177.
311 Day 184, p.178.
312 SJM 475.

the HSCB provided a record which showed that HIA 176 was already smoking before she was admitted to the school.[313]

260 HIA 233 told us that she started smoking at the age of thirteen in St Joseph's because cigarettes were handed out at regular intervals during the day by the nuns and that she still smokes the same brand of cigarette today.

261 SR 235 explained that most of the girls who arrived in St Joseph's were already smoking and while that was not encouraged neither was preventing them from smoking a major priority. She explained that girls could buy cigarettes with their pocket money but they had to hand them in and staff gave them out at regular intervals during the day. She accepted:

> "With the benefit of hindsight and given the knowledge which is now available in relation to the dangers of smoking, I accept that permitting smoking was not in the best interests of the girls."[314]

We accepted SR 235's explanation and found it reasonable. Therefore, we found no systemic failing in relation to girls being allowed to smoke in St Joseph's.

Lack of Preparation for Leaving Care

262 The importance of preparing girls for life after care was recognised as early as 1952. Dr Simpson and Miss Forrest recorded in their report of the inspection they completed of the school in December 1952 that the new system of aftercare was working well and that SJM 44 visited the school regularly to get to know her future charges.[315]

263 SR 240 told us that in the 1970s a licensing committee operated that was a review committee made up of two members of the Board of Management and three or four external professionals, who were responsible for reviewing girls two to three months before they were due for release. She explained that the committee would interview each girl and relevant members of staff to ensure sufficient preparation had been made to enable her to transfer from care. In particular, the committee would focus on what job opportunities and accommodation were available to her and what further support could be given to her so that she could be released on licence.[316]

313 SJM 22259.
314 SJM 216.
315 SJM 1284.
316 SJM 885.

264 HIA 203 complained about a lack of preparation for leaving care and that she was removed by SJM 44 and taken to live with a relative with whom she was not familiar. When HIA 203 was shown contemporaneous correspondence and records she accepted that SR 237 contacted her relatives to try and make arrangements for her and that she was taken to Belfast for a job interview although she has no memory of that happening. However, she insisted that plans for her future were never discussed with her and that she felt unprepared for the move and was not given the opportunity to say goodbye to her sister.[317] When she gave evidence in person HIA 203 acknowledged that some time after she left St Joseph's she got into trouble and had to complete a prison sentence and that SR 237 arranged a hostel placement for her on her release from prison.[318]

265 HIA 161 also told us that she had very limited preparation for her departure from St Joseph's. When she gave evidence in person she was shown copies of contemporaneous documentation that showed the nuns were liaising with her relatives and potential employers about possible openings for her but HIA 161 said she knew nothing about this and that she remembered being given ten-minutes notice of her departure.[319]

266 HIA 175, who was in the school from 1972 to 1974, told us that the training she received in Middletown helped her to get a job at a home for older people which was arranged by staff in Middletown. She stayed at that job for a short period before moving to a better job.[320]

267 Sister Canice Durkan, who worked in St Joseph's from 1987 until it closed in 2000, had a particular responsibility for organising aftercare for girls and although she spent time in the school she was not attached to one of the houses.[321] She explained that former residents would keep in touch with staff and that outreach work continued with girls after they had settled in their own homes and in some cases had children.[322]

268 While it is clear that some of the applicants were not aware of the efforts being made on their behalf to organise appropriate aftercare arrangements for them, we were convinced that the school did its best to organise accommodation and employment for girls and maintained contact with

317 SJM 056.
318 Day 184, pp.34 to 35.
319 Day 184, p.167.
320 SJM 22240.
321 Day 187, p.169.
322 Day 187, p.170.

girls and welcomed them back to St Joseph's for visits after they were discharged from the school.

269 We have considered the statements we have received about unacceptable practices, the responses to them from the Sisters of St Louis, contemporaneous records and the findings of inspectors, and have concluded that there were no unacceptable systemic practices in St Joseph's.

Conclusion

270 Given the positive assessments by inspectors of the care provided in St Joseph's throughout the decades and the accounts from some witnesses about how well they were treated in the school it is perhaps not surprising that we only received a small number of complaints about the school.

271 We carefully considered the evidence in relation to SR 237 and concluded that she was physically abusive to girls to the extent that it amounted to systemic physical abuse.

272 We found that the ICU was used appropriately and not over-used and that girls were not merely contained there but were given time to calm down, reflect on their behaviour and to consider how better to manage it in future. We were convinced that when SR 240 was in charge the emphasis was in supporting and developing girls and helping them to understand and manage their behaviour and to develop their self-esteem and confidence. We found contemporaneous evidence that staff maintained good contact with girls' social workers and worked with them to develop and review care plans. Evidence from inspections indicated that girls were encouraged to maintain contact with their families, and family members were made to feel welcome when they visited St Joseph's.

273 We found some evidence of overt favouritism being shown by some staff to chosen girls and while we consider this poor practice that should have been identified and addressed we did not consider that it amounted to systemic abuse.

274 The work of St Joseph's was supported by a level of state funding that was generous in relation to voluntary children's homes and meant that a good staff-resident ratio could be maintained, which enabled the provision of individual attention to girls and the creation of a more home-like environment. The stability of the workforce was also a positive factor that assisted in the provision of consistent standards of care and a

confident approach to working with girls, many of whom displayed very challenging behaviour including significant self-harm. The staffing ratio and consistency of the workforce was greatly assisted by the availability of the sisters who worked in the school and in particular those sisters who were senior managers. Inspectors found these senior managers were readily available to the girls despite their additional responsibilities for overseeing the operation of the school, liaising with government officials and being accountable to the Board of Management. It was clear that SR 240 in particular was successful in attracting funding for the school and persuading officials that specialist well-resourced care in appropriate surroundings with high quality facilities was needed to address the increasing complexity of the difficulties experienced by girls being placed in the school.

275 In addition to our finding in relation to SR 237 we found that the lack of formal inspections in the period from 1968 to 1987 was a systemic failing by the MoHA, and then the NIO, to ensure that St Joseph's was providing proper care and meeting statutory requirements about the operation of training schools. This meant girls in the school at that time did not have the benefit of external monitoring of the facilities and practices in the school. However, once Mr Donnell was seconded to provide professional advice to the NIO about the running of the school and a programme of inspections was established and implemented there was a high level of detailed scrutiny of and support to the school.

276 Our consideration of St Joseph's was assisted by the detailed records and diaries that were maintained in the school and retained by the congregation. They provided a clear picture of how the school was developed and operated over the decades and recorded levels of interest in, and concern for, the girls which demonstrated that the ethos, principles and policies that underpinned the school were genuinely applied in practice.

Summary of Findings

We found the following systemic failings in relation to St Joseph's.

The Ministry of Home Affairs and the Northern Ireland Office:

277 **The lack of formal inspections in the period from 1968 to 1987 was a systemic failing by the MoHA, and then the NIO, to ensure that St Joseph's was providing proper care and meeting statutory requirements about the operation of training schools. This meant**

girls in the school at that time did not have the benefit of external monitoring of the facilities and practices in the school. (Para. 57)

Sisters of St Louis

278 **During the period of SR 237's directorship, between 1957 and 1971, she was physically abusive to girls to the extent that it amounted to systemic physical abuse. (Para. 160)**

Chapter 19:

Module 8 – Barnardo's

Introduction

1 The Inquiry devoted Module 8 to the examination of evidence relating to two homes run by the organisation now known as Barnardo's, but for most of that time as Dr Barnardo's, in Northern Ireland. These homes were known as Macedon and Sharonmore, and were dealt with in the same module because Sharonmore succeeded Macedon, and many of the applicants, and much of the evidence, related to a period when some of the applicants were in one or other of the two homes. As will be apparent from the evidence we consider, some at least of the issues and the evidence relating to these issues overlap both homes.

2 The Inquiry devoted two weeks covering eight sitting days between 7 December 2015 and 17 December 2015, during which we heard oral evidence from three applicants and received the written statement from a fourth. We also received oral and written evidence from Lynda Wilson, the Director of Barnardo's Northern Ireland, and from five former employees of Barnardo's. The Inquiry tried unsuccessfully to locate BAR 2, but on 17 December 2015 he made contact with the Inquiry. He was then provided with the relevant evidence, and ultimately provided the Inquiry with a statement dated 24 February 2016. He was offered the opportunity to give oral evidence but declined to do so.[1]

3 Our investigations have not been limited to the matters raised by the evidence of the four applicants, because we also considered material obtained by the Inquiry from Barnardo's and from other sources, particularly from the police, relating to the care provided by Barnardo's to the children in both Macedon and Sharonmore.

4 A substantial part of the material considered by the Inquiry during this module related to allegations that resulted in a major police investigation into the actions of two former staff members of Barnardo's who were employed at either Macedon or Sharonmore. These two individuals, to whom we shall refer as BAR 1 and BAR 2, were the subject of a Crown Court prosecution in 2004 based upon the evidence of ten individuals, nine of whom were former residents - the tenth being the child of a former staff member. Following the convictions of BAR 1 and BAR 2 on many, but not all, of the charges against them, both appealed to the Northern Ireland Court of Appeal. In 2005, after considering new evidence, the Court of Appeal quashed their convictions and decided not to order a retrial on those charges in respect of which they had been convicted at the Crown

1 BAR 2546-2548.

Court. The effect of the acquittals at the Crown Court, and the quashing of the charges in relation to which they had been convicted, was that BAR 1 and BAR 2 were acquitted of all of the charges against them.

5 Because of the nature of the allegations it was necessary for us to consider afresh the evidence relating to the allegations which led to the police investigation and the subsequent prosecution. Although the allegations we considered mostly related to the period 1977 to 1981, we have also considered events that are alleged to have occurred outside that period, and for that reason we have followed a broadly chronological approach when considering these allegations.

6 We had written submissions from a number of those who were the subject of allegations, as well as submissions on behalf of Barnardo's, the Department of Health, Social Services and Public Safety (DHSSPS) as the successor department to the Ministry of Home Affairs (MOHA) and the Department of Health and Social Services (DHSS), which had statutory responsibility for these homes during the period with which we are concerned. We also received written submissions on behalf of the Health and Social Care Board (HSCB), as the successor to the various local or statutory authorities which had responsibilities for the care of children they placed in Barnardo's. We have considered all of this evidence and paid careful attention to the various submissions made to us. However, in accordance with our general approach, we do not propose to refer to every allegation that was made, whether against an individual or against Barnardo's, although we have taken all of the evidence and the submissions into account.

Macedon

7 Macedon was a large Victorian house set in substantial grounds at Whitehouse on the north-side of the shores of Belfast Lough. It was bought by Barnardo's and registered by the Ministry of Home Affairs as a voluntary children's home on 29 June 1950. It accommodated children between the ages of 16 and 18 years, and in its early days had a feeder home called Manor House in Ballycastle, Co Antrim (not to be confused with Manor House, Lisburn, which we consider elsewhere in our Report). Manor House was approximately 55 miles from Macedon, and was a home for babies and toddlers. It accommodated approximately 50 children at any one time, who then progressed to Macedon.

8 Barnardo's built two purpose-designed cottages in the grounds of Macedon.

In later years there were generally 30 children resident in Macedon at any one time, with ten in the main building, and ten in each of the cottages. Initially Macedon was registered to accommodate 35 boys and girls, and although it was originally intended to be a single sex facility, in order to meet the needs of the time and to facilitate family groups, both boys and girls were accepted, with flexibility as to admitting children of different ages. Altogether 598 children passed through Macedon in the 31 years of its existence, and by June 1981 all the children in residence had moved from Macedon to Sharonmore.

9 During its existence Macedon offered long, medium and very short-stay placements, although in the years leading up to its closure in 1981 the placements were predominantly long-term in nature. Described by Barnardo's as a "traditional Children's Home", as the years went by Macedon increasingly catered for children who were from a very disturbed and difficult background, many of whom would otherwise have been placed in a training school if Barnardo's had not undertaken to care for them.

10 In January 1958 it was registered for 52,[2] but by 1979 the numbers had been reduced to 32.[3] It appears that in the early 1970s two factors coalesced that led to Macedon being closed and being replaced by what was known as the Sharonmore Project. One was that in 1971 Dr Bywaters, Barnardo's Medical Officer, visited Macedon and raised queries as to whether it was appropriate to have as many children on site as the 52 who were in Macedon at that time.[4] It is clear that the numbers had increased from the original permitted maximum of 35.

11 This questioning of the justification for such a large institution reflected a change in mainstream childcare thinking at that time. BAR 14, who became Barnardo's Divisional Director for Northern Ireland in 1974 shortly after he had joined Barnardo's, explained in his evidence that when he joined Barnardo's a replacement home for Macedon was being planned for a location at Ballyhanwood at Dundonald on the outskirts of East Belfast. The plans had reached the stage at which they were about to go out to tender, but he and the chief architect of Barnardo's agreed that the new facility would be what he called a "white elephant"[5] and the plan was scrapped. This facility may well be what Dr Bywaters meant in 1971

2 BAR 25007.
3 BAR 25188.
4 BAR 624.
5 Day 171, p.22.

by the "new home", when he asked "...are we right in replacing the same number in the new home as there are at Macedon?"[6]

12 The other factor was that the projected M5 motorway would result in the compulsory purchase of Macedon and its closure.

Sharonmore

13 BAR 14 explained how the scrapping of the proposed replacement home for Macedon at Ballyhanwood resulted in a process of Barnardo's thinking through what was required to replace Macedon. BAR 24 prepared a document called "The Sharonmore Project", based upon discussions he had with local staff. This eventually emerged as Macedon's replacement. The Sharonmore Project, as it was known, (although for simplicity we refer to it simply as 'Sharonmore'), was a response to the Black Report,[7] and by and large catered for more disturbed children than Macedon.[8]

14 Sharonmore had a number of components. Ballyduff House in Newtownabbey was purchased from Newtownabbey District Council. It was called the Parent Unit and contained the administrative functions of Sharonmore. In addition there were two separate, purpose-built, living units: Ballyduff and Ravelston. Ballyduff accommodated eight young people in four single and four double rooms. It closed in February 1985 and the children and staff in Ballyduff transferred to Ravelston. The Ravelston Unit accommodated eight young people in eight single rooms. Both Ballyduff and Ravelston had a "sleeping in" room for staff whose turn it was to be on call at night, and a spare room that could be used for parents and friends.[9]

15 In addition there were two satellite units at Ballysillan and Derrycoole. Each satellite unit was an ordinary dwelling house, both within five miles of Ballyduff, with four young people each in single bedrooms. Derrycoole was closed and deregistered as a children's home in January 1996.

16 Unlike Macedon, Sharonmore was community based. Each unit was physically much closer to ordinary neighbours than many traditional children's homes at that time, with children attending schools, churches and recreational facilities in the community, and medical facilities were

6 BAR 624.
7 Report of *The Children and Young Persons Review Group* (1979). Sir Robert Black was chairman of the Review Group.
8 BAR 22034.
9 BAR 690.

provided by a local GP at the local health centre.[10] Each child had a key worker, and the individual units were intended to provide a range of social work interventions for the children in their care, as may be seen from the following extract from a statement to the Inquiry by Lynda Wilson, Director of Barnardo's Northern Ireland:[11]

> "Initially, the Ballyduff Unit was intended to provide a residential social work service, which was task-centred, for children who presented with social, emotional and behavioural difficulties. The social work interventions were designed to help these children reflect on their difficulties and to understand better the reasons underlying them, in order to gain control over their actions and begin to take responsibility for them.
>
> "The Ravelston Unit was designed to help young people presenting with social, emotional and behavioural difficulties through the provision of a residential social work service, which provided individualised care with focus on specific tasks including preparation for independent living.
>
> "The Satellite Units aimed to provide residential social work interventions providing individualised care with their focus on specific tasks to children who would benefit from living in a small unit in the community. In the Satellite Unit, care was on a domestic scale to replicate some aspects of substitute family care, while maintaining a professional approach to problem-solving."

HIA 417

17 The first allegation we considered was that of HIA 417 who was in Macedon between 1967, when she was thirteen, to 1973, when she was nineteen. She was the only applicant from this period to make allegations of abuse. She was placed in Macedon by Tyrone County Welfare Committee and said that she did not remember visits by a social worker. Whilst Barnardo's records only refer to one such visit, there was substantial correspondence relating to her between Barnardo's and the Tyrone welfare authorities, and there were also efforts to maintain links with her family.

18 She described how she witnessed the then superintendent of Macedon BAR 5, dragging other girls by the hair, and Barnardo's concede that there were concerns in 1969 about his leadership and management skills; his

10 BAR 690.
11 BAR 690-691.

skill in dealing with staff was regarded as problematical, as was notably, his limited capacity to handle girls. We accept that HIA 417 was pushed and shoved by BAR 5 as she alleges. However, as hers is the only allegation of such behaviour relating to this period we do not consider that sufficient to amount to a finding of systemic abuse.

19 She also complained of being bullied and sexually abused by older girls. We accept this occurred, but she did not tell staff what was happening to her, and as there is no other evidence of bullying and sexual abuse of other children at this time, we do not consider the abuse she suffered amounts to systemic abuse.

20 She alleged that she was not given sufficient encouragement or opportunity to achieve her full potential academically. We note that at the time she was felt to be very intelligent. Concerns were noted about the standard of her homework at the time, and it was to be more closely supervised in future.[12] Although we sympathise with HIA 417's frustration at her lack of academic achievement while she was in the care of Barnardo's, we consider that Barnardo's ensured that she had as good an education as many other children who were not in residential homes at that time. We are satisfied that Barnardo's did as much as they could to point children towards occupations that could be expected to provide a realistic opportunity for them to acquire the necessary skills to enable them to become financially independent once they left the home. We do not regard Barnardo's efforts in her case as indicative of any systemic failing on the part of Barnardo's.

Allegations relating to BAR 3

21 BAR 3 was employed at Macedon as an assistant house parent from 23 April 1979 until 9 January 1980.[13] His employment was terminated because it came to light that he had borrowed money from petty cash and from children's pocket money.[14] BAR 8 described to the Inquiry how he had borrowed money from her and from other staff. On one occasion she had to pay £40 to the child because he was unable to pay money back to allow a child to buy clothes, and it seems that it was her report about this that led to his employment being terminated after he repaid the money.

12 BAR 591.
13 BAR 5922.
14 BAR 5924.

22 It is clear that this was not the only aspect of his conduct that was suspect. In her evidence BAR 8 described to us how he wore a large cross around his neck as if he were a priest.[15] BAR 9 confirmed that BAR 3 represented himself as a member of a Roman Catholic religious order.[16] BAR 8 said how he called himself doctor and carried a doctor's bag and stethoscope.[17] She was told he was treating staff and children for headaches, and giving the staff powders. BAR 14 later described BAR 3 as having "an effeminate manner and one is inclined to the view that he is most certainly homosexual",[18] and BAR 9 referred to BAR 3 as wearing eye shadow.[19]

23 We consider that BAR 3's behaviour in describing himself as a priest and doctor (neither of which appears to be true judging by the absence of references to any such qualifications in his application form), and borrowing money, could have led to his services being dispensed with before the report from BAR 8 that he had taken money from a child's pocket money. His behaviour was bizarre, and in itself was sufficient to call into question his suitability to work with children because he was clearly not who he purported to be. **The failures to detect these matters, and then take appropriate action, represented systemic failures because they demonstrated either a lack of knowledge or an unacceptable tolerance of what was happening among the staff on the part of management at Macedon.**

24 In 1981 it came to light that allegations had been made by BAR 46 that BAR 3 (who left Barnardo's in January of that year)[20] had tried to kiss him on a number of occasions.[21] It appears from a memorandum made some months later that these allegations were originally made to BAR 2. He reported them to his supervisor BAR 8. She does not appear to have reported what BAR 2 said to her for some time, to judge by the note made by the Superintendent BAR 24.[22] In that memorandum BAR 24 recorded that BAR 8 told him that BAR 2 had told her about these matters "some months ago". The memorandum is dated 21 April 1980 and implies that he was told on 11 April 1980.

15 Day 169, p.124.
16 Day 172, pp. 110 and 115.
17 Day 169, p.124 and following
18 BAR 5944.
19 Day 172, p.115.
20 BAR 4237.
21 BAR 4242.
22 BAR 4242.

25 In a statement which she made to the police[23] BAR 8 claimed that when BAR 24 did not get back to her she took her complaints to BAR 14, who was then Barnardo's Divisional Children Officer/Director of Childcare in Northern Ireland. A memorandum written by BAR 14 on 17 April 1980 makes no reference to the allegations made by BAR 46, although (as stated above) he did record that BAR 3 "has an effeminate manner and one is inclined to the view that he is most certainly homosexual. However, this was never a problem, as far as his work was concerned, except that some children made reference [to it]".[24]

26 In his statement and oral evidence to the Inquiry BAR 14 said that he had no recollection of BAR 24 speaking to him about this. When BAR 8 gave evidence to the Inquiry she accepted that although she recalled mentioning a number of the things about BAR 3 to which BAR 14 referred in his note, she did not think that she had mentioned the kissing incident to him, because she thought that as she had spoken to BAR 24 about it and he had said that he would go to BAR 14 about the matter, that would be sufficient. We accept that BAR 14 was not told by BAR 8 that BAR 3 was alleged to have kissed BAR 46. BAR 14's memorandum is entirely consistent with his not being told. We are satisfied that if BAR 14 had been told of the kissing he would have recorded it.

27 The memorandum of 21 April 1980 contains the following passage:

> "As these reported incidents took place some months ago, the member of staff has now left our employment (9.1.80)…on considering the situation in my judgement any well intentioned cross-examination at this late stage might do damage to all concerned, especially in view of the climate in the province at present."[25]

28 The reference to the "climate in the province at present" appears to be a reference to the recent disclosure in the media that a number of members of staff at the Kincora Boys Home were alleged to have committed serious sexual offences against the children in their care, allegations which were subsequently found to be well-founded in view of the pleas of guilty of the three men concerned, although that did not take place for some considerable time after the writing of this memorandum.

23 BAR 8502.
24 BAR 5924.
25 BAR 4242.

29 We are satisfied that the allegation that BAR 46 had been kissed by BAR 3 was not passed on by BAR 24 to BAR 14 as it should have been. Had it been passed on, then it would have been essential for Barnardo's to report these allegations to the police and to the Eastern Health and Social Services Board (EHSSB) in whose care the child was and who had placed the child in Macedon. The failure to report the allegations meant that no steps were taken to investigate whether BAR 3 had made sexual approaches to any other child, and, if he had, to do whatever was necessary to assist the child. Had the matter been reported to the EHSSB that would have allowed the Board to consider whether it was satisfied that the children it had placed in Macedon were free from any risk of abuse. Had the matter been reported to the board and to the police it would have enabled both to try to investigate the actions of BAR 3 with a view to his being prosecuted and thereby prevented from abusing other children. BAR 3 died aged 47 on 13 September 1993 in the Republic of Ireland.

30 From the medical evidence presented to the Inquiry on his behalf, we were satisfied that BAR 24 was not capable of assisting the Inquiry in relation to his recollection of these events and why he acted as he appears to have done.

31 BAR 14 said in his witness statement to the Inquiry:

> "I do not know what BAR 24 had in mind in making this judgement, but I do not think that he was referring to the political climate or the troubles in Northern Ireland. It seems more likely that he had in mind the turmoil that existed amongst residential care staff as a result of the Kincora saga and the range of allegations and disclosures that were emerging at that time at a number of other homes. Residential staff felt under-valued and mistrusted and low morale was widespread."[26]

And at paragraph 28:

> "Having read his File Note[27] for the first time within the last few weeks, I cannot fully understand how he came to the conclusion that he did. Nor do I understand why he did not make me aware of what had been brought to his attention regarding BAR 3. I am content that he made his decision in good faith, motivated by his desire to do what he felt at that time was in the best interests of a young person."[28]

26 BAR 1143.
27 BAR 4242
28 BAR 1143.

32 The Inquiry put to BAR 14 the possibility that a factor was that,

> "To draw these matters to the attention of their proper authorities might result in unfavourable attention being directed towards Barnardo's?"

He accepted that was certainly a possible implication but he did not think that BAR 24 would have concealed the matter in that way. He accepted that he was influenced by the man whom he knew and whom he made it clear he held in very high regard as someone whom he respected and whose professional and moral integrity he valued.[29]

33 Another possible reason may have been a desire to protect the reputation of Macedon and its staff, and the reputation of Barnardo's, in the media, because we recognise that once allegations such as these are aired publicly, whether there is any substance to them or not, they can have a severe impact on staff morale and on staff retention and recruitment.

34 The view of Lynda Wilson about this was set out in her witness statement when she said that, "the first task of the Superintendent was to find out the facts. This did not happen and as a result, Barnardo's failed to address potential child abuse".[30]

35 Whatever the reason may have been, we are satisfied that BAR 24 took a deliberate decision not to report the full nature of the allegations to his superiors, not to report the allegations at all either to the police or the EHSSB, and not to investigate the allegations further. His failure to do any of these things was wholly unacceptable. His duty as Superintendant was to find out the facts so that Barnardo's could establish whether or not BAR 3 had made sexual advances to any other children in their care and he failed in that duty.

36 His failures had another extremely important consequence. The Hughes Inquiry appears to have only been made aware of one episode of sexual abuse of a child in the care of Barnardo's during its terms of reference, namely that involving BAR 44 which we consider later in this chapter. We are satisfied that had BAR 24 reported these matters to his superiors at the time Barnardo's would then have reported them to the EHSSB and to the police. Had a conviction followed that would have resulted in these matters being investigated by the Hughes Inquiry. Because these matters were not reported, the Hughes Inquiry could not be made aware of them, and Macedon was not investigated by the Hughes Inquiry in the way that Sharonmore was.

29 Day 172, p.33.
30 BAR 048.

37 More than 30 years later we cannot be sure what would have come to light had the EHSSB, the police and the Hughes Inquiry learnt of the allegations about BAR 3's conduct in Macedon. Nevertheless, we are satisfied that the opportunity to uncover and investigate the allegations about BAR 3, and quite possibly the allegations made many years later about BAR 1 and BAR 2 as well, was missed because of BAR 24's failure to report the allegations about BAR 3 to his superiors as he should have done.

38 It emerged during the Macedon Inquiry, which we consider later in this chapter, that after BAR 3 left Barnardo's employment BAR 46 said to BAR 75 that BAR 3 "was a real fruity boy" and "had tried to touch him up". By this time BAR 46 was in either Macedon or Sharonmore. Because BAR 3 had left Barnardo's employment at that stage, BAR 75 does not seem to have reported the remark to his superiors at Barnardo's.[31]

39 The way BAR 3's behaviour was dealt with by different individuals within Barnardo's was unsatisfactory in the ways that we have identified. Nevertheless, we should record that although BAR 14 was not told of matters about BAR 3 that he should have been, in his memorandum of 17 April 1980 to the personnel manager, to which we have already referred, BAR 14 said that:

> "he had grave doubts as to [BAR 3's] reliability, and certainly would not recommend him for a position of trust, or for any post in a social work setting."[32]

40 This was clearly designed to prevent BAR 3 being given a favourable reference from Barnardo's should he apply for a job with another employer in this field. That was an effort to protect any children with whom BAR 3 might otherwise have been able to work in future.

41 Barnardo's accept "the failure to take appropriate steps in response to the [BAR 46] allegation about [BAR 3] constitutes a systemic failing".[33]

42 **We are satisfied that there were several systemic failings in the way in which this matter was handled by Barnardo's staff at the time:**

- **BAR 75 does not seem to have reported the remarks by BAR 46 to his superiors.**

31 BAR 8619.
32 BAR 5924
33 BAR 21090

- **They were not reported for some months by BAR 8 to BAR 24. BAR 24 made a deliberate decision not to report the full facts to his superiors or to anyone else.**

Barnardo's handling of other sexual allegations by children in Macedon or Sharonmore

43 BAR 47 is a sister of HIA 516. She did not apply to the Inquiry, but the Inquiry considered events relating to her because of material it obtained in respect of a number of matters with which she was concerned. The first of these events occurred on 20 February 1981 when she told BAR 8 that whilst on a home visit to her father BAR 30 he attempted to pull down her underpants and touched her about her chest below her sweater. She was almost fifteen at the time. The matter was promptly reported to the police who investigated the matter, although it appears that no prosecution resulted.

44 Her complaint in 1981 is relevant because:

- BAR 47 felt able to disclose a sexual assault to Barnardo's staff.

We are satisfied that on this occasion Barnardo's dealt appropriately with this allegation.

45 The second event involving BAR 47 occurred on 17 May 1982, when she informed BAR 9 that she had had sexual intercourse with her then boyfriend a few days before during a period when she had absconded from Sharonmore. This was also promptly reported to the police by Barnardo's staff. During the investigation BAR 47 told the police that intercourse had been consensual. She also told the police that before intercourse had occurred she had been a virgin,[34] something that will be significant when we consider other allegations she made subsequently. This matter was also dealt with by Barnardo's in an appropriate fashion.

The attitude of Barnardo's and the EHSSB towards the relationship between BAR 12 and HIA 516

46 Barnardo's first became aware of BAR 12 when BAR 8 approached BAR 14 because of the interest expressed by police from Newtownabbey in setting up a trust fund for HIA 516. The interest shown by other officers appears to have waned after a time, but BAR 12 was encouraged by

34 BAR 8732.

Barnardo's staff to focus his attention on one child, rather than on all the children in the unit.[35] At this point BAR 12 should have been assessed as an individual volunteer or as a 'befriender', but this seems to have been overlooked. From January 1980 BAR 12 took a considerable interest in HIA 516,[36] but it was only in February 1981 that Barnardo's decided to place this interest on a more formal 'befriender' basis. Hilary Reid, (now Dr Hilary Harrison), who was at that time a project leader for Barnardo's at another home, was asked to perform an assessment of BAR 12 because "some concern was expressed about the relationship and the benefits or otherwise of this".[37]

47 She carried out two long interviews of BAR 12. She was uncomfortable about being asked to perform this task when a relationship had already been going on for some fifteen months, and as she did not know the child concerned. However, she sensed that information may have been deliberately withheld from her so that she would approach her task in a completely unbiased way. Whilst on one view it might have been better if she had been fully briefed about HIA 516, and about BAR 12's failure to follow all the guidance given to him about how to approach HIA 516 by the staff at Macedon, nevertheless it is important to bear in mind that BAR 12 held a responsible position, Barnardo's were unaware that there had been concern expressed by his senior officers about his attitude to children in the past, and HIA 516 did not make any allegations against BAR 12 until June 1982.

48 Dr Harrison told the Inquiry that she had nothing to suggest that BAR 12 would have had any interest in HIA 516 sexually when she carried out her interviews with him. She made no recommendations when she submitted her report in April 1981, pointing out that she was unaware of the whole picture.[38]

49 In the light of what was to happen subsequently she made a particularly prescient observation in her conclusion when she said:

> "…how much he is prepared or willing to accept the guidance of others, however, is difficult to say. I feel his own needs might tend to override his better judgement".

35 BAR 7108
36 BAR 7107.
37 BAR 11428.
38 BAR 11434.

50 BAR 14 told the Inquiry that while it was unusual to assess a potential befriender after the befriender was allowed to develop that relationship with the child, his opinion was that there seemed to have been thorough consideration of the relationship both by Barnardo's and by the EHSSB, (which had placed HIA 516 with Barnardo's), there had been consultation and the matter had been well handled.[39]

51 Lynda Wilson took a different view. While she pointed out that there was no suggestion of interference of HIA 516 by BAR 12 at that time, and BAR 12 was a trusted member of the community, it was at least poor practice to leave the befriending assessment to a point where the issues had become problematic. She accepted that whether or not abuse had occurred the befriending assessment should have started earlier.

52 Whilst we accept that it was entirely justifiable for Barnardo's to accept BAR 12's willingness to befriend HIA 516, who was a boy with a very disturbed and difficult history, nevertheless a formal befriending assessment should have been carried out at the start of the relationship, and not fifteen months later. In addition, the unwillingness of BAR 12 to follow the advice given to him on several occasions during 1980 by Macedon staff should have been dealt with more firmly at the time.

53 As can be seen from Dr Harrison's assessment report, and from the detailed report prepared by BAR 111 (then in charge of Barnardo's in Northern Ireland), in 1980 BAR 12 was putting substantial amounts of money into HIA 516's post office savings book virtually every month. He had also given him a stereo unit and records at Christmas 1980. By the time Dr Harrison carried out her meetings with BAR 12 in February 1981, he was paying for riding lessons for HIA 516 each week.

54 On 14 May 1981 BAR 111 Assistant Divisional Director (Child Care) Irish Division, wrote to BAR 12 to record the outcome of a meeting held with him on 6 May 1981 to discuss his relationship with HIA 516. BAR 111 confirmed that Barnardo's and the EHSSB were prepared to agree to the relationship continuing subject to conditions. These conditions were that BAR 12 accepted the guidance of Macedon staff about the nature and length of time he spent with HIA 516, including his plans for trips out with him, and the value of presents and amounts of money he intended giving him. This letter was copied to BAR 60, Assistant Principal Social Worker, EHSSB and senior members of Macedon staff.[40]

39 Day 171, pp.63 to 64.
40 BAR 16115.

55 In June or July 1981[41] (and not October 1981 as stated by BAR 111),[42] BAR 12 bought a pony for HIA 516 for £300, and paid for its board and feed until the end of May 1982.[43] The farmer who sold the horse told the police that on numerous occasions BAR 12 brought HIA 516 out to ride the pony, and "he was also brought out sometimes by the home".

56 It is unclear when Barnardo's staff knew that BAR 12 was going to buy the pony, but he had indicated to Dr Harrison in February 1981 that he would be willing, if HIA 516 proved interested enough, to buy him a horse.[44] Whether Barnardo's or the EHSSB knew that BAR 12 was going to buy the pony, it seems that Barnardo's staff allowed HIA 516 to continue to use the pony after it was bought.

57 That BAR 12 bought the pony so soon after BAR 111 wrote to him was a significant breach of the conditions. We consider that he should not have been permitted to continue the relationship with HIA 516 after the meeting of 6 May 1981. We are satisfied that BAR 12 had clearly shown himself to be unwilling to abide by conditions which Macedon staff sought to impose upon him before that meeting of May 1981. He should not have been permitted to continue his relationship with HIA 516 after that meeting because he had repeatedly shown an unwillingness to abide by the advice of Barnardo's staff and the willingness of Barnardo's to allow the relationship to develop. By November 1981 Barnardo's had come to the conclusion that the conditions that had been made clear to BAR 12 were not being complied with, and that he was to have no further contact with HIA 516.

58 The length of time that it was allowed to continue after BAR 12 had repeatedly shown an unwillingness to abide by the advice of Barnardo's staff represented poor practice. Lynda Wilson conceded that Macedon's systems were not sufficient in terms of how these matters were dealt with,[45] and **we consider the manner in which this relationship was allowed to develop, and the length of time for which it was allowed to continue, represented systemic failures by Barnardo's to ensure proper child care of HIA 516.**

41 BAR 7136.
42 BAR 7113.
43 BAR 7136.
44 BAR 11432.
45 Day 172, p.2.

The allegations by HIA 516 against BAR 12

59 The next allegation in chronological sequence relates to an allegation relating to BAR 12 by HIA 516. In October 1980 an oral complaint was made to Newtownabbey Police Station (where BAR 12 was stationed at the time) that staff at Barnardo's were concerned about the relationship between him and HIA 516. The complaint was apparently reported by the detective constable who received the call to the Sub Divisional Commander at Newtownabbey RUC Station but it would seem that no further action was taken at that time.[46]

60 The next relevant development was that on 6 October 1981 BAR 30 phoned Newtownabbey police and complained that his son HIA 516 was 'overly friendly' with BAR 12 who had bought him a stereo and a pony. The reference to the stereo presumably related to the stereo unit and records BAR 12 bought for HIA 516 at Christmas 1980.[47] The reference to the pony clearly relates to the purchase of the pony referred to above.

61 Although BAR 30 subsequently withdrew his complaint, it was investigated by Newtownabbey police at that time, and an inspector spoke to Barnardo's staff and to BAR 30, but not, it seems, to HIA 516.

62 As it happens, as part of his investigation into allegations concerning Kincora, Detective Superintendent Caskey interviewed BAR 12 on 16 April 1982. In the course of that interview BAR 12 was asked about his relationship with HIA 516, and it is clear from the question that Superintendent Caskey was aware of at least some of the details of that relationship, notably that HIA 516 had a pony.

63 On 28 April 1982 Detective Chief Inspector Colgan was directed to carry out investigations into a number of associations giving rise to what he termed as "suspicions" that BAR 12 had displayed:

> "an inordinate and unhealthy interest in certain youths whom he had met in the course of his police duties and whom he had afterwards befriended and associated with".[48]

64 One of these associations was with HIA 516, who by that time had been transferred from Macedon to Rathgael Training School. DCI Colgan interviewed him on 25 June 1982 about his relationship with BAR 12.

46 BAR 7063.
47 BAR 7113.
48 BAR 7058

During the interview HIA 516 became distressed and ultimately made a written statement alleging that BAR 12 had:

- Given him gifts of the stereo and the pony and money – usually £2.50 a time.
- Bought pornographic books.
- Put his arm round him and tried to kiss him.
- Tried to get him to touch BAR 12's penis.
- Exposed his erect penis and tried to get HIA 516 to touch it.
- Asked HIA 516 to masturbate him.

HIA 516 said he resisted all of these approaches.

65 BAR 12 was subsequently interviewed on 6 August 1982 about these allegations. He responded by saying he "just simply had no comment or rather no answer". He denied being homosexual, or having homosexual tendencies.

Later that month, HIA 516 indicated he wished to see DCI Colgan again, and an interview was held on 19 August 1982. HIA 516 told him he had been thinking it over, had told his mother, and that things had gone further than he had said. HIA 516 said he was not prepared to go to court, but would give evidence against BAR 12 at any police disciplinary proceedings.

66 Two written statements were recorded. In the shorter statement[49] HIA 516 said what he had earlier alleged was correct, except that BAR 12 had stopped about four times at a quarry near the riding stables, and that he had visited BAR 12's home in Bangor about six times, and not twice as he had earlier alleged.

67 In the longer statement[50] he described in considerable detail his relationship with BAR 12. So far as sexual abuse is concerned, the salient allegations were:

- On the first day BAR 12 took him out he tried to open his trouser buttons.
- A week after the purchase of the pony BAR 12 had shown him a book with pictures of nude men and women, and offered him three more similar books to keep, but he refused.

49 BAR 7141.
50 BAR 7142.

- On another occasion BAR 12 felt HIA 516's penis through his trousers.
- On a further occasion BAR 12 tried to open his trouser buttons.
- On the first visit to BAR 12's home in Bangor, he tried to kiss him on the mouth.
- On subsequent visits BAR 12 had again tried to kiss HIA 516 and get his trousers down.
- On the last visit BAR 12 was able to get HIA 516's trousers and underpants down to his ankles, then sat on him and masturbated HIA 516's penis to an erection, before HIA 516 punched him on the back, whereupon BAR 12 stopped.

68 HIA 516's mother BAR 112 made a statement[51] to the effect that when her son told her that BAR 12 had been "messing" with him she assumed her son had been anally raped. She went to BAR 12's house and confronted him. He denied these allegations, and asked her whether she thought his father had put him up to it, to which she replied that he might have.[52] She signed a statement to that effect prepared for her by BAR 12 and his brother-in-law (also a police officer).[53] She said when she called to the house, "I had drink on me, but I was not drunk". She then went to Greencastle RUC station with BAR 12, his sister and his brother-in-law, but the station sergeant refused to accept the statement because the matter was already the subject of an internal police investigation. The sergeant also considered that she had consumed a considerable amount of drink before coming to the station.[54]

69 The DPP directed no prosecution. The directing officer, while acknowledging that the relationship of BAR 12 with HIA 516 was suspicious, stated that there was no corroboration, pointed out that there were significant discrepancies in the accounts given by HIA 516, and observed that HIA 516 was clearly disturbed, violently anti-police and anti-authority, and widely reported by responsible people as being, among other things, a liar.[55]

51 BAR 7145.
52 BAR 7146.
53 BAR 7070.
54 BAR 7070.
55 BAR 7056

70 These matters resurfaced in March 1997 when HIA 516 wrote to the Chief Constable of the RUC renewing his allegations against BAR 12, making further allegations about him, his father BAR 30, and BAR 1. In this letter[56] he gave a different version of being indecently assaulted by BAR 12 in his car, and added a new allegation of a violent anal rape during a car journey back from the riding stables to Macedon. He described this in his police statement[57] but did not refer to the incident in BAR 12's house in Bangor, Co Down.

71 It appears that he was asked by the investigating police inspector why he had not mentioned the alleged anal rape during the 1982 allegations, to which HIA 516 offered no explanation. The police pointed to the absence of corroboration, the passage of time since the alleged anal rape (fifteen years) before the complaint was made to the police, and the problems with the credibility of HIA 516 because he was serving a ten-month sentence in the Republic of Ireland for indecent assault on a fifteen-year-old female, and was awaiting trial on a charge of rape of his niece for which it seems he was subsequently convicted and sentenced to twelve years imprisonment. The DPP directed no prosecution.

72 HIA 516 was only fifteen and in Rathgael Training School when he made the original allegations against BAR 12. Although he did not advance any explanation fifteen years later as to why he did not mention the alleged violent anal rape in 1982, it is unclear how closely he was questioned in 1997 as to why this was the case. It is possible that in 1997 the police and the DPP may not have given any, or sufficient, weight to what is now a well recognised tendency for victims of sexual abuse to be reluctant to disclose all, or the most serious, abuse to which they were subjected when they first disclose some allegations.

73 Looking at the evidence as a whole relating to HIA 516's allegations of abuse against BAR 12, the relationship of BAR 12 with HIA 516 is strongly indicative of a pattern of grooming by BAR 12 of a young, vulnerable child by lavishing gifts and attention on the boy, and having the opportunity to sexually abuse the boy when HIA 516 was away from Macedon where he was living.

74 However, we have not had the benefit of oral evidence from HIA 516 or BAR 12, although both submitted written statements to the Inquiry. On

56 BAR 7198
57 BAR 7029.

the evidence presently available to us we do not feel able to reach a definite conclusion as to whether HIA 516 was subjected to sexual abuse by BAR 12 while HIA 516 was in the care of Barnardo's, although the relationship of BAR 12 with HIA 516 gives rise to considerable suspicion.

75 These allegations were unknown to Barnardo's at the time because they were not made until after Barnardo's and the EHSSB believed that the relationship between BAR 12 and HIA 516 had been brought to an end in November 1981, although later there were grounds to believe that BAR 12 and HIA 516 continued to have contact with each other in March 1982. That was because HIA 516 arrived back in Sharonmore from school with cigarettes, sweets and money. On 17 March 1982, when he did not return, a staff member contacted BAR 12 who said he would look for him. BAR 12 brought HIA 516 back to Sharonmore at approximately 5.30 pm; it seems that HIA 516 had been at a roller disco.[58]

76 It is also important to bear in mind that at that time Barnardo's were not aware of the police suspicions about BAR 12. On the basis of what Barnardo's knew, or ought to have known, in 1981, we cannot be satisfied that if HIA 516 was subject to sexual abuse by BAR 12, Barnardo's was guilty of a systemic failure in not preventing any abuse that may have occurred.

The allegations relating to BAR 44

77 BAR 44 was a thirteen-year-old boy with a very disturbed history who was admitted to Sharonmore from Rathgael Training School in October 1981. He was truanting from school and was picked up in Belfast City Centre by a delivery man on his rounds. The man persuaded the boy to join him on his delivery rounds and sexually assaulted him. Some days later BAR 44 told his uncle what had happened, and his uncle informed Barnardo's. It promptly informed the Southern Health and Social Services Board (who had placed the boy in Sharonmore) and the police. The matter was investigated by the police, the perpetrator was traced and questioned, and admitted the offences. He was prosecuted, pleaded guilty and sentenced.

78 This episode came to the attention of the Hughes Inquiry, and as a result it investigated Sharonmore and the way it was run in considerable detail. The Hughes Inquiry was satisfied that Barnardo's took all necessary steps to assist the police fully in relation to this matter.[59] We agree. They promptly

58 BAR 7113.
59 BAR 22008

reported the allegations to the police, and a member of staff accompanied BAR 44 when he was interviewed by the police.

79 The Hughes Inquiry also examined Barnardo's policy and practice in a number of areas, such as record keeping, recruitment and training of staff, strategic planning and compliance with the 1975 Voluntary Homes Regulations, and we will comment on these matters later in this Chapter.

The 1985 complaint by HIA 216 against BAR 4

80 HIA 216 was in Macedon from 1967 (when she was aged five) until she left in March 1981 aged eighteen and a half. She remained friendly with BAR 8 who visited her from time to time. On 24 April 1985 BAR 8 visited her at her home; by then HIA 216 was aged 22. A note made of that visit by BAR 8 records that the purpose was to discuss something that HIA 216 had told her in confidence, "some time ago".[60] When that was is unclear, the note saying that HIA 216 had given information to BAR 8, "at a much earlier date". In any event, the note makes it clear that although HIA 216 had not wished to pursue the matter, BAR 8 had discussed it with her project leader and a decision had been made to approach HIA 216 again. BAR 8 persuaded HIA 216 to discuss what happened to her in greater detail, and HIA 216 told BAR 8 she had been sexually assaulted by BAR 4. We will consider the details of the allegations later.

81 It is clear from a note made by BAR 8 of a further visit to HIA 216 on 10 July 1985 that in the interim Barnardo's had been gathering information. The matter was then reported to the police by BAR 79, Barnardo's Divisional Director, (Child Care).[61]

82 While this account might suggest that thus far Barnardo's dealt appropriately with this disclosure by HIA 216, there is evidence to suggest that that was not in fact the case. BAR 8 said that when she discussed the position with BAR 79, his reaction was to say that as HIA 216 had left Barnardo's a long time ago, there was nothing Barnardo's could do about it, and it was for HIA 216 to contact the police. BAR 8 responded:

> "Well I know that, but there is [sic] other children who were working/living down in Macedon and something could have happened then".

60 BAR 227.
61 BAR 17630.

To which she alleges he replied:

> "you are not to go to any child to ask them about anything. They must come to you first and make a statement".[62]

However BAR 8 disobeyed this direction and went back to HIA 216, as BAR 8 recounted to Lynda Wilson in 1999.[63]

83 We are satisfied that BAR 79's initial reaction was not to follow up the implications of these allegations, despite the risk to children elsewhere that might arise if the alleged abuser was not investigated, as well as the possibility that any investigation might reveal that other children in Macedon had been abused by the alleged abuser. As we have stated, the allegations were later reported to the police in August 1985. **We consider the reluctance on the part of some Barnardo's staff in Northern Ireland at that time to report such matters to the proper authorities was a systemic failing.**

84 We now turn to consider whether HIA 216 was the subject of sexual abuse by BAR 4. When she made her statement to the police in 1985 she alleged that when she was thirteen or fourteen two types of incident occurred. The first occurred in one of the cottages at Macedon when he put her hand down the front of his trousers. The second occurred some weeks later and involved him stopping the car on the way back to Macedon from his house in Lisburn. She alleges that he touched her on the breasts and below her waist, but stopped when she told him to stop.[64] The DPP directed no prosecution, it would seem because there was no corroboration and because of the delay in reporting the matter.[65]

85 In 1999, by now aged 37, HIA 216 made further allegations against BAR 4 in the course of a further statement she made to the police during an investigation that resulted in the prosecution of BAR 1 and BAR 2. On this occasion HIA 216 considerably expanded her allegations.

- She said she was abused by him in the cottage, "at least 10 times".
- In the cottage, in addition to putting her hand down the front of his trousers, he pulled up her nightie, felt around her breasts and vagina, inserted his finger in her vagina, and on a couple of occasions made her masturbate him.

62 Day 169, p.90.
63 BAR 17791.
64 BAR 7614.
65 BAR 8470.

- On the car journeys back from Lisburn he kissed her, made her masturbate him, inserted his finger into her vagina, and on maybe three or four occasions made her perform oral sex on him.
- On at least three occasions on such journeys he forced her into the back seat and held her by the throat while he vaginally raped her, as well as anally raping her on one or two occasions.
- On two or three occasions while in BAR 4's house in Lisburn, and while his wife was watching, he took his penis out of his trousers and made her touch it. He also put his hand inside her underwear and rubbed around her vagina, again while his wife was watching.[66]

86 At the beginning of the 1999 statement HIA 216 explained that when she made the 1985 statement she felt that the police woman who took the statement was just not interested. She felt that she had been thrown in at the deep end and was expected to tell the police woman everything the first time HIA 216 had met her. She also said that BAR 8 was not allowed to come into the room at the police station when the statement was being taken.

87 In her evidence to the Inquiry HIA 216 said that although she had told a friend at the time that BAR 4 had put his hand around her privates (and she also referred to telling her friend in the 1999 police statement), she had not told her or the police about the rapes "because I just felt ashamed", and that "...even getting out that first part about BAR 4 was hard enough without anything else".[67]

88 BAR 4 and his wife were interviewed by police in 2002 in Wales where they were living by that time. Both denied all the allegations. By this time BAR 4 had been convicted in September 1992 of five charges of indecent assault, three involving males and two involving females, one of whom was his daughter. In the course of that investigation he admitted touching his daughter and getting her to masturbate him,[68] but denied that sexual intercourse had occurred. He admitted in engaging in mutual masturbation with a teenage boy, and that he and his wife and this boy had engaged in sex together.[69] He also admitted that he was sexually interested in both male and female children.[70] His wife was convicted in

66 BAR 7615-BAR 7621.
67 Day 170, p.22.
68 BAR 7706.
69 BAR 7691.
70 BAR 7707.

1991 of the offences of having intercourse with two under-age teenage boys.

89 Whilst the DPP directed no prosecution in relation to HIA 216's allegations against BAR 4, there are two other matters that are of some significance in respect of these allegations. The first is that she told the police that BAR 4 had a mole or birthmark or something like that, a brown colour, definitely not a tattoo on the top half of his body, although she could not remember where, or if it was on the front or back of his body.[71] BAR 4 admitted that he had a small mole less than one quarter of an inch in size just above his belly button, although he claimed HIA 216 could have seen it when he washed or came downstairs while looking for a shirt or something.[72]

90 The second matter is that HIA 216 said that while she was still at Macedon she went into the office of BAR 23, who was the superintendent of Macedon at the time, intending to complain to him about BAR 4. Although we are satisfied that HIA 216 is mistaken when she says that BAR 8 was present, we accept that there was such an occasion. In May 1985 BAR 28 typed a note for the record, her memory having been jogged while typing BAR 8's note about her discussions with HIA 216.[73] In 2001 BAR 28 made a police statement in which she said she remembered very clearly HIA 216 coming into BAR 23's office and saying that she wished to speak to him, but then turning red and leaving the room when she realised that BAR 4 was also in the room. BAR 28 said that BAR 23 went after HIA 216 to speak to her, and when he came back asked BAR 4 how she had been during their meeting, why was she upset and did he know what HIA 216 wanted to speak about. BAR 4 said that he had no idea what was wrong with HIA 216. BAR 23 was described as being perplexed by this incident.[74]

91 Elsewhere we have considered other allegations made by HIA 216, and have taken all of the evidence relating to those other allegations into account when assessing her evidence about BAR 4. We are satisfied that HIA 216 was sexually abused by BAR 4 in the manner she described to the police in 1985, but we are not persuaded to the required standard that the abuse she described as suffering at the hands of BAR 4 in her later accounts to the police went beyond the matter she originally alleged.

71 BAR 7620.
72 BAR 7742.
73 BAR 8462.
74 BAR 7645/46.

92 Although we are satisfied that HIA 216 was sexually abused by BAR 4 to the extent we have just described, we are not satisfied that this was due to any systemic failing on the part of Barnardo's. At the time Barnardo's had no reason to believe that BAR 4 was behaving inappropriately towards HIA 216, or that he posed a danger to her or any other child at Macedon. He was with Barnardo's in the summer of 1977 as part of a scheme that enabled him to work there on placement for some months before he left the Army.

93 Although a more rigorous vetting procedure of the type that is standard practice today might have revealed what appears to have been a highly sexualised environment in BAR 4's home, such a rigorous vetting procedure would not have been good or standard practice at that time. Whilst we consider BAR 79's initial reluctance to report the matter when it first came to his attention in 1985 was poor practice, the situation was rectified without excessive delay, although in large measure this was due to the persistence of BAR 8 in pursuing the matter.

94 Nevertheless, the amount of unsupervised access BAR 4 was permitted to have to HIA 216, and the failure of Barnardo's to check the home environment, were unacceptable by the standards of the time. It is noteworthy that in 1972 Mr Bunting of the EHSSB told all voluntary homes that even if children were only going out for a day this had to be approved by the Board.[75] Barnardo's have told the Inquiry that they think the Board was not informed. **We consider the amount of unsupervised access by BAR 4 to HIA 216, and the failure of Barnardo's to inform the EHSSB that this access was taking place, represented systemic failures by Barnardo's to provide proper childcare.**

The decision by Barnardo's to retain BAR 1 in their employment

95 BAR 1 was 41 when she joined Barnardo's staff on 1 April 1977 as a nursery officer at Barnardo's Day Care Centre at Windsor Avenue, Belfast. As was standard practice she was placed on a six month probationary period.

96 It is clear that she was not regarded as a satisfactory employee when dealing with small children, and on 9 November 1977 she was notified

75 RUB 5569.

that a decision had been made not to confirm her appointment. However, she appears to have persuaded Barnardo's that, notwithstanding her poor record when dealing with children of nursery school age, she would nevertheless be suitable to work with older children. On 18 November 1977 Barnardo's decided to accept her application to transfer to work at Macedon because she had experience of working with older children, and because she held a recognised residential childcare qualification. She was appointed as a residential social worker at Macedon with effect from 1 December 1977, again subject to a six month probationary period.[76]

97 Seventeen months later she was promoted to the position of third senior, effectively the third in command in her unit, with effect from 1 April 1979, again subject to a six month probationary period. As we shall see, this promotion took effect a short time after what we later refer to as 'the wooden spoon incident' in February 1979.

98 On 29 June 1981, three and half years after she had been appointed to Macedon, and 26 months after she had been promoted to third senior, she transferred to Sharonmore. By that stage all the children at Macedon had moved to Sharonmore[77], but by 1 March 1982 her performance was considered unsatisfactory, and disciplinary action and demotion were suggested.[78]

99 It seems that there was no improvement in her work, and disciplinary proceedings in September of that year resulted in her being given a formal warning.[79] In March 1983 her work was still regarded as unsatisfactory, and the highly unusual sanction of the deferral of an annual increment to which she would normally have been entitled occurred for the second time.[80]

100 Although it appears that she then tendered her resignation on 26 April 1983,[81] for some reason which cannot now be established she was allowed to remain in post. Her work was regarded as unsatisfactory, and on 21 July 1983 the warning period was extended for a further year and she was warned about her lack of ability to work with and to control children.[82]

76 BAR 5880.
77 BAR 4329.
78 BAR 5884.
79 BAR 5893
80 BAR 5896.
81 BAR 5901.
82 BAR 064.

101 On 1 December 1983 she was transferred to another project run by Barnardo's at Tara Lodge House in Belfast as a disciplinary measure. On 1 January 1984 she struck a child with a Scholl-type wooden shoe or sandal,[83] disciplinary proceedings were instigated and she then resigned.[84]

102 Despite a highly unsatisfactory employment record over the previous two years, BAR 79, then the Divisional Director of Barnardo's in Northern Ireland, told her that if she ever needed a reference she should contact him.

103 Her employment record has to be viewed against a number of issues which were known about at the time.

The wooden spoon incident in 1979

104 BAR 1 left £100 in her handbag in the sleeping-in room at Macedon. Some two weeks or so later she discovered that £30 was missing from her handbag, and on 6 February 1979 she accused HIA 101 of stealing the money. The events that then occurred were subsequently recorded by BAR 14 in a lengthly file note.

105 The initial reaction of one of Barnardo's staff, BAR 35 was to smack HIA 101 on each hand with a wooden spoon, and then she went to report the matter to BAR 7 who was the Acting Superintendent of Macedon at that time. After BAR 35 left to make this report another staff member, BAR 76 and BAR 1 also struck HIA 101 with a wooden spoon. BAR 76 slapped him on the legs, and BAR 1 struck him on the bottom, both also using a wooden spoon.[85]

106 As BAR 14 observed in his note, the three members of staff each punished HIA 101 without consultation with each other, or without reference to the Superintendent, actions he described as "completely indefensible".[86] He also noted that HIA 101 was punished in a number of other ways. He was not allowed to go home to his grandmother, and he was told he was not allowed to use a bicycle he had been given by BAR 8. As BAR 14 commented to the Inquiry, HIA 101 was effectively being punished several times for the same offence, something that was "totally unacceptable".[87]

83 Day 172, p.70.
84 BAR 5905.
85 BAR 148.
86 BAR 134.
87 Day 171, p.46.

107 The theft was reported to the police and to her superiors by BAR 7. She required each of the three staff to enter what they had done in the punishment book. The matter was investigated by BAR 14. While all three staff members who struck HIA 101 were admonished, and a note placed on their personal file, no formal disciplinary action was taken against them.[88] BAR 14 was asked by the Inquiry whether he felt this was the appropriate way to deal with the matter and he stated that he felt that the line taken was probably proportionate. We accept that when this episode came to the knowledge of the Acting Superintendent at Macedon it was promptly and thoroughly investigated by her and management.

108 In July 1977 Barnardo's issued a circular to all its staff throughout the United Kingdom and Ireland relating to Care and Control.[89] This expressly stated that the only form of corporal punishment that was permitted was an occasional smack on the hand for children who were under the age of ten (and who were not handicapped).[90] Any other form of corporal punishment was forbidden, including the use of any implement.[91] No doubt to emphasise the importance of adherence to this policy, and the gravity with which a breach would be regarded, the document stated that "Any breach of these rules by a member of staff may lead to disciplinary action which could include dismissal" (emphasis added).[92]

109 **We consider that the episode, and the way it was dealt with, reveal a number of systemic failings on the part of Barnardo's.**

- **There was no preliminary investigation of the theft by staff before the child was punished.**
- **The three staff who struck HIA 101 acted in breach of Barnardo's policy prohibiting the use of any implement by way of corporal punishment.**
- **That each resorted to the use of a spoon in such an impulsive fashion suggests to us that this was not the only occasion that staff resorted to a wooden spoon to administer minor corporal punishment.**
- **We consider that to admonish the three staff, and to place a note on each of their personal files, was an inadequate and inappropriate response. They had individually and collectively**

88 Day 171, pp 45 and 47.
89 BAR 22272.
90 BAR 22273.
91 BAR 22274.
92 BAR 22274.

behaved in a very unprofessional manner, and we consider that the proper course to have taken at that time would have been for each to have received a formal written warning.

Ghost stories and the "evil eye"

110 There was considerable evidence before the Inquiry that BAR 1 was in the habit of telling children ghost stories in thoroughly inappropriate circumstances, and grimacing at them in a way which led them to think that she was giving them the "evil eye". BAR 1 told the police that the children called her "evil eye" and that she had told them ghost stories,[93] although she maintained that the lights were always on on such occasions.[94]

111 However, we are satisfied that BAR 1 was in the habit of telling children very frightening ghost stories, and on many occasions did so in the dark. For example, BAR 55 (who was in Macedon from the age of nine in 1973 until 1977 when she was thirteen) described BAR 1 as playing games in the dark, moaning like a demon and trying to catch the children.

112 These accounts were not limited to children, because several staff described what happened during a police investigation in 2001. BAR 35 described how BAR 1 would tell ghost stories with the lights out and "seemed to get the children excited which was the last thing needed around bedtime. It must have been done regularly because I can remember them", and "there was a mixture between kids being frightened and enjoying it".[95] Other staff such as BAR 76, BAR 91, BAR 113 and BAR 92 gave similar descriptions, BAR 92 describing the children being chased around at bedtime and saying that BAR 1 "was unsettling the kids around that time".[96] BAR 75 told the police that he had instructed her in 1981 not to tell ghost stories.[97]

113 No doubt, as a number of the staff maintained, some at least of the children in Macedon enjoyed having ghost stories told to them and on some occasions this may have been done in the dark. We are satisfied from the various accounts given by children and others to the police in 2001 that it was well known that BAR 1 regularly chased children in the grounds and told ghost stories involving her moaning and jumping

93 BAR 4910.
94 BAR 4914.
95 BAR 4540.
96 BAR 4606.
97 BAR 4630.

at children. A number of Barnardo's staff seem to have seen nothing untoward or wrong in this, but others clearly disapproved of her behaviour because this was resulting in a number of children being frightened whilst others became excited and difficult to settle down before bed.

114 We consider that this went much too far and was a practice rightly stopped by BAR 75 in 1981. It should not have been permitted to the extent that it was. Whilst we accept that a rare treat might have been to tell children ghost stories, to do this on a regular basis in the manner in which it was done was a highly undesirable practice. It frightened and upset many children when they should have been preparing to settle down for bed. We are satisfied that it was a completely unacceptable practice which was well known to Barnardo's staff who either condoned it or failed to intervene to stop it until BAR 75 stopped it in 1981.

115 **We consider that the way in which this was allowed to happen amounted to a systemic failing, and that it went unreported and/or undiscovered for several years by senior managers responsible for the home represented a failure by Barnardo's to exercise proper supervision.**

116 We consider this to be a further sign of BAR 1's unsuitability in any capacity to work at Macedon. Whilst BAR 1 held a childcare qualification, it is apparent to us that she was unsuitable to work in Macedon, and it is questionable whether she should have been permitted to transfer to Macedon from Windsor Avenue when her suitability there was found to be unsatisfactory. The fact that she was repeatedly permitted by senior management to continue in her employment having been found to be unsatisfactory is something we find inexplicable, particularly in the light of her known conduct in relation to ghost stories and grimacing in a way which led impressionable children to believe that she was in some way exercising power over them. It is particularly surprising that she was promoted so soon after the wooden spoons incident in 1979.

117 Irrespective of the nature of her conduct in other matters which we shall consider in due course, **we are satisfied that Barnardo's was guilty of a series of systemic failings in relation to her employment.**

- **She should not have been retained as an employee for several years, let alone promoted, when it was clear that she was unsatisfactory in the manner that we have described.**

The relationship between BAR 1 and Joseph Mains

118 As appears in that part of our report relating to Kincora, Joseph Mains was in charge of Kincora Children's Home from when it opened in 1958 until he was the subject of a police investigation in 1980. That resulted in his being charged with sexual offences against a number of children, charges which he ultimately admitted and for which he was subsequently sentenced to a period of imprisonment. The relevance of Mains to this chapter stems from his relationship with BAR 1.

119 BAR 1 said in her Inquiry Statement that they:

> "...went out together. After the Kincora scandal broke I broke our friendship off. He contacted me again when he was in prison and I felt sorry for him and visited him. I also visited him when he was dying in hospital in Coleraine".[98]

However, the evidence before us establishes that the relationship between BAR 1 and Mains when the Kincora investigation started was a long-standing one and more than one of friendship, and that BAR 1 was formally engaged to Mains. BAR 7 said that she believed that it was a formal engagement,[99] and Lynda Wilson recalled that BAR 1 had an engagement ring.[100] As part of the Terry Inquiry BAR 1 made a statement to Chief Inspector Flenley of the Sussex Police on 1 April 1982 in which she admitted that Mains had been her steady boyfriend for twenty years, that they had become officially engaged two or three years before (i.e. in 1979 or 1980), and that they went out socially together, including going to dances and dinner dances.[101]

120 We are satisfied that when it first became known that Mains was being investigated in relation to alleged sexual offences against children in his care it was well known to Barnardo's staff at Macedon that there was a close relationship between Mains and BAR 1.

121 We must emphasise that the Inquiry has found no evidence to suggest that Mains had any improper connection with Macedon, or with any child whilst that child was in the care of Barnardo's. Nevertheless, when it became known that Mains was alleged to have sexually abused children in his care, Barnardo's should have taken steps at that time to investigate

98 BAR 2533.
99 Day 170, p.107.
100 Day 172, pp.160 to 61,
101 KIN 40609.

the extent of the relationship between Mains and one of their staff to try to establish whether that relationship involved any risks to the children in Barnardo's care. No consideration appears to have been given by anyone at Barnardo's at the time to taking such steps.

122 In her evidence to the Inquiry, Lynda Wilson conceded this was a failing on the part of Barnardo's, because Barnardo's recognised that there should have been management consideration of the situation, and as a point of good management practice there should have been consideration and a proactive plan put in place at that stage.[102]

Barnardo's accept that "the failure to address, by way of risk assessment and management, the engagement of a member of staff to a person charged with sexual offences against children is...a failing".[103]

123 **We agree that the failure of Barnardo's management to investigate the nature of Mains' connection with BAR 1 and Macedon represented a systemic failing on the part of Barnardo's.**

124 Lynda Wilson felt that it was surprising that BAR 1 was kept on by Barnardo's as long as she was. She explained that at that time in particular a lot of effort would have been made to keep giving people a chance to do better. Nevertheless, she felt that in BAR 1's case that was a mistake.[104] While it is understandable that Barnardo's wished to support staff, we feel that indicated a willingness to put the interests of staff above the well-being and protection of children.

125 **We consider that BAR 1 had shown herself to be a completely unsatisfactory employee to be placed in the care of children for a considerable period of time before she finally resigned. Barnardo's failure to terminate her employment at an earlier stage represented a systemic failing on its part to ensure that suitable staff were in place to look after the children in its care.**

HIA 50

126 HIA 50 spent two periods in Sharonmore, the first for eight months in 1985 when he was fifteen, and the second for six months in 1986. HIA 50 alleged that during his time in Sharonmore he was anally raped by HIA 516 in a launderette in Ravelston. HIA 516 has denied this. He

102 Day 172, pp. 135 to 136 and 157 to 160.
103 BAR 21093.
104 Day 172, p.163.

was a former resident of Sharonmore, and Barnardo's accept that he probably did return from time to time after he left in 1982. It is noteworthy that in 1985 he was banned from entering Sharonmore because he had threatened a young boy there, and in December 1986 police had to be called to remove him from Ravelston. We also note that HIA 516 has a substantial criminal record including convictions for common assault, attempting to pervert the course of justice, two offences of unlawful carnal knowledge, as well as convictions for rape in the Republic of Ireland and England. Barnardo's paid £5000 compensation and his legal costs to HIA 50 in respect of this incident.

127 HIA 516 responded to the Inquiry Warning Letter and denied the allegations. However, we accept that HIA 50 was sexually abused, but we also accept that at the time Barnardo's had no reason to believe that he was at risk from HIA 516. Given that Barnardo's had no reason to believe that, and that they tried to keep HIA 516 away from Sharonmore when HIA 50 was there, we do not consider that the sexual abuse suffered by HIA 50 was due to any systemic failing on the part of Barnardo's.

128 HIA 50 has also complained that on one occasion he was taken in a Barnardo's staff car by BAR 8 when she went to pick up another child living in Sharonmore from her home on the Shankill Road in Belfast. This is a Protestant area but HIA 50 is a Roman Catholic, and he felt extremely frightened when two brothers of the girl tried to get into the car. He alleges that BAR 8 locked the car doors, and slapped him on the face. He believes that she deliberately set up this incident, and part of his complaint is that she did not report the incident afterwards.

129 BAR 8 gave evidence that no such episode occurred involving her and HIA 50. Barnardo's disclosed to the Inquiry a report of a different incident involving another staff member collecting the same girl from her home when the girl was late and had been drinking.[105]

130 Having considered all of the evidence relating to this matter, in the absence of conclusive evidence we are not persuaded that there were any systemic failings on the part of Barnardo's.

105 BAR 098

The Macedon Police Investigation

Background

131 In March 1997 HIA 516 wrote to the Chief Constable of the RUC. As a result he was interviewed by officers of the RUC in the Republic of Ireland where he was serving sentences imposed on charges of unlawful carnal knowledge, as well as awaiting trial on charges of rape and indecent assault.[106] In his police statement at 6 May 1987 HIA 516 made allegations that he had been subjected to abuse by three individuals. One was his father BAR 30. Another was BAR 12 and we have considered the allegations made against BAR 12 earlier in this chapter. The third person was BAR 1. These allegations were investigated, and in September 1997 the DPP directed no prosecution against each of these three individuals.

132 Whilst these matters were being investigated, the police learnt of further allegations by BAR 46 that he had been sexually abused by BAR 3 on an overnight trip to Dublin. It subsequently transpired that BAR 3 died in the Republic of Ireland in 1993,[107] although the police were unaware of that when they carried out this investigation.

133 In June 1998 allegations were made by BAR 47 a sister of HIA 516 and by HIA 101 his brother, that they too had been sexually abused during their time in Macedon.[108]

The Police Investigation

134 As a result of these additional allegations the police launched a wider investigation into Macedon covering the period from 1 December 1977, when BAR 1 started to work at Macedon, and 30 May 1984 when she stopped working for Barnardo's. This investigation also dealt with allegations against BAR 2 who worked at Macedon during part of that period.

135 With the assistance of Barnardo's, the police identified 51 people who had been in either Macedon or Sharonmore as children between these dates. Thirteen of the 51 could not be located, were confirmed to be deceased, or were unwilling to speak to the police. Twenty-seven said that they were not abused and were unaware of abuse. Thirteen of the 51

106 BAR 8102
107 BAR 8651.
108 BAR 4243.

ex-residents made allegations of abuse. One withdrew his allegation, one would not confirm his verbal allegation in writing, the third was murdered and there was no corroborative evidence of his allegations. As well as the ten remaining ex-residents, two children of a former staff member at Macedon also made allegations of abuse, making twelve people in all who alleged that they were abused during this period.

136 The allegations pursued by the police related to four individuals, namely BAR 1, BAR 2, BAR 3 and BAR 52. The DPP subsequently directed no prosecution of BAR 52. As we have already stated, at this time the police were unaware that BAR 3 had died, and because he had not yet been traced only BAR 1 and BAR 2 stood trial.

137 An unusual feature of the proceedings was that before the trial Barnardo's settled claims for compensation by nine of the ten individuals who alleged that they had been sexually and/or physically abused by BAR 1 or BAR 2 for amounts ranging from £15,000 to £25,000. Seven of the nine claims were settled within a few days of each other early in January 2003. The only one of the ten individuals who had not brought a civil claim against Barnardo's at that time was HIA 516.

The Trial

138 A lengthy trial of BAR 1 and BAR 2 took place in 2004. BAR 1 was charged with 105 offences against ten individuals, nine of whom were ex-residents of Barnardo's and one who had been a child of a former staff member who worked for Barnardo's. The trial judge directed that she be acquitted on thirteen charges, and that twelve charges be "stayed" (meaning that the prosecution was not allowed to proceed with the charges, but no verdict was taken). BAR 1 was convicted on 52 charges relating to eight of these individuals, and was sentenced to a total of eleven years imprisonment.

139 BAR 2 was charged with 60 offences against six ex-residents. He was convicted on seventeen charges relating to four of them. He was acquitted by direction of the trial judge on 33 charges, and found not guilty on the remainder. BAR 2 was sentenced to fourteen years in prison.

140 Two matters relating to the trial and its outcome are worthy of particular note:

- BAR 47 did not appear to give evidence in support of the allegations relating to her, and so her evidence on which these charges were based was not considered by the jury who were directed by the

trial judge to acquit both BAR 1 and BAR 2 where those charges depended upon the evidence of BAR 47.

- Although HIA 516 gave evidence at the trial, at the end of the prosecution case the trial judge ordered that the twelve charges against BAR 1 that depended on his evidence should be "stayed" because the charges were an abuse of the process of the court as BAR 1 had been informed by the DPP that she was not to be prosecuted in respect of those charges. The effect of this ruling was that the jury did not have to reach a verdict on the allegations made by HIA 516.

Events before the hearing of the appeal

141 Both BAR 1 and BAR 2 appealed against their convictions. Prior to the appeals being heard by the Court of Appeal, BAR 37, who had given evidence for the prosecution at the trial, wrote a series of letters which were to prove highly significant. One of these was to BAR 2. In this letter,[109] which appears to have been written on 26 January 2005, BAR 37 made several important assertions.

- He had undergone a religious experience.
- BAR 1 was innocent and he would not be surprised if BAR 2 was innocent as well.
- A great injustice had taken place and he would come forward and tell the truth.
- HIA 216 and BAR 29 were lying about BAR 1, and so he believed they were lying about BAR 2 as well.

142 In March 2005 BAR 37 wrote another letter to BAR 89,[110] a social worker. He again said that he had undergone a religious conversion and that he wished to put right the injustice he had caused. In this lengthy letter he made the following assertions.

- BAR 1 was innocent of any of the sex charges against her.
- BAR 1 had frightened him and had given him the evil eye.
- That was why he gave evidence against her.
- BAR 1 had only nipped him while bathing him.
- He would now tell the truth although the others may stick to their lies.

109 BAR 4218.
110 BAR 9477.

- It would not surprise him if BAR 2 were innocent as well.
- That he had told his sister BAR 38 what to say about an incident that he had described involving BAR 1 and his sister and himself whilst both children were in the bath together.

143 As a result of these disclosures the police interviewed BAR 37 and he made a statement on 3 June 2005.[111] In this statement BAR 37 purported to recant what he had said in the various letters, and in particular that at BAR 9477. He asserted that he had said these things because he was angry at not being visited in prison by BAR 89, or by anybody else from Barnardo's, and because BAR 3 had been acquitted on a charge of buggery of him. He explained that his reason for saying that he had lied during the trial was the belief this would mean someone would come to visit him in prison, and that what he had said about others lying at the trial was untrue. He also said that he had not told his sister what to say about the bath incident.

The evidence given to the Court of Appeal

144 Before the Court of Appeal dealt with the appeals against the convictions by BAR 1 and BAR 2 it heard evidence from a number of those who had given evidence at the trial, namely BAR 37, BAR 39, BAR 38 (sister of BAR 37), and the investigating officer in the case, Detective Sgt Boyce. BAR 89, the social worker who had been closely connected with some of the witnesses, also gave evidence. Several, notably BAR 39 and BAR 89, were rigorously cross examined by defence counsel over an extended period of time. The Court of Appeal later expressed its opinion upon some of the witnesses who had given evidence before it, and on some of those who gave evidence during the trial.

The outcome of the appeal

145 After the appeal, the Court of Appeal delivered three judgements. The first was an ex tempore, oral, judgement quashing the convictions.[112] This was followed by a written judgment confirming and amplifying the reasons already given.[113] Finally, on 16 September 2005 the court delivered a second written judgment giving its reasons for not ordering a retrial of

111 BAR 9491
112 BAR 4120.
113 BAR 4112.

BAR 1 and BAR 2 on the various charges in respect of which they had been convicted.[114] As we have already indicated, the outcome of the trial and of the appeal was that BAR 1 and BAR 2 were acquitted of all of the charges against them.

146 It is essential to remember that the acquittal of any defendant on a criminal charge does not necessarily mean that some or all of the evidence upon which the criminal charges were based was untrue, only that the prosecution have failed to establish his or her guilt to the high criminal standard of proof beyond reasonable doubt.

147 It is therefore perfectly possible that in such circumstances some or all of that evidence may nevertheless satisfy the lower standard of proof on the balance of probabilities applied by a civil court, or by an inquiry such as this Inquiry. Although Barnardo's payments of compensation made before the trial to a number of the witnesses at the trial shows that Barnardo's accepted that it was legally liable to those individuals, all of whom gave evidence at the trial, Lynda Wilson explained to the Inquiry that Barnardo's does not take issue with the decision of the Court of Appeal, and it recognises that it is not for Barnardo's but for the Court or this Inquiry to determine the allegations to whatever extent is necessary.[115]

148 Our Terms of Reference require us to determine whether there were systemic failings on the part of those responsible for residential homes for children, in this case by Barnardo's. We have to take account of all the evidence now available to this Inquiry to establish whether on the balance of probabilities abuse occurred which could give rise to findings that there were systemic failings on the part of Barnardo's towards the children in its care. This includes us giving proper weight to any material that affects the reliability of some, or all, of the evidence of witnesses during the trial of, and during the appeal by, BAR 1 and BAR 2.

149 In particular it requires us to take into account that the evidence of individual witnesses has been exhaustively probed in cross examination, either at the trial or before the Court of Appeal. Where the evidence of an individual witness has been shown to be either untrue or unreliable in important respects at the trial or before the Court of Appeal, then we have to take that into account when deciding to what extent, if any, we can regard the evidence of that witness as reliable.

114 BAR 4105.
115 Day 172, p.132.

150 We have concluded that the judicial criticisms of the evidence of several of the witnesses whose evidence was relied upon to support the criminal charges against BAR 1 and BAR 2, criticisms which led the Court of Appeal to quash their convictions on the charges upon which they were convicted, mean that we cannot rely on their evidence alone. We have also considered the evidence of other witnesses relied upon to support the convictions of BAR 1 and BAR 2. We have not had the benefit of hearing oral evidence from the other witnesses, or from BAR 1 or BAR 2, although both provided written statements to the Inquiry denying that they committed any offences.

151 Because this was a criminal investigation it was concerned with possible offences and was not concerned with probing issues of a childcare nature. As a result, inevitably issues of systemic failings relating to the care provided for children were only touched on incidentally.

152 Taking all of these factors into account, we consider there is insufficient reliable evidence to satisfy us that the more serious allegations of sexual and physical abuse made against BAR 1 and BAR 2 by witnesses other than BAR 46 and BAR 39 have been established to the civil standard of proof on the balance of probabilities.

153 For these reasons we consider that we must leave out of account the allegations of abuse against BAR 2, and the greater part of the allegations of abuse against BAR 1, when deciding whether there were systemic failings in the care of children provided by Barnardo's at Macedon.

154 As a result, we are left with only the evidence of BAR 46 and BAR 39 relating to BAR 1. We have considered that evidence very carefully. Some of their evidence supports the conclusions we have already expressed about BAR 1 frightening children by telling them ghost stories, chasing them in the dark and pretending she had the evil eye. We are not persuaded by the remainder of their evidence, which was relied upon at the trial to establish the more serious allegations of sexual and physical abuse of children in either Macedon or Sharonmore made against BAR 1 and BAR 2.

155 Looking at the evidence as a whole we are persuaded that BAR 1 engaged not only in the ghost stories and other related matters to which we have already referred, but also engaged in inappropriate bathing of male children who were of an age when they should have been left completely to bath themselves, as other witnesses alleged in their statements to the police, and not assisted to do so by BAR 1. **We regard this as an unacceptable practice which should not have been allowed to occur.**

That it was allowed was due to inadequate supervision of BAR 1 by management at Macedon, and amounted to a systemic failing.

156 Nevertheless, it is also clear from statements made to the police during this investigation that there was corroboration of some parts of the account by BAR 47 of her relationship with BAR 2.

- Several staff members observed that BAR 47 appeared to be very fond of BAR 2. BAR 9 told the Inquiry he warned BAR 2 to be careful.[116]
- BAR 47 agreed that she borrowed BAR 2's ring on occasion. This also is confirmed by BAR 9.[117]
- The then Superintendent of Macedon, BAR 23 (since deceased) objected to BAR 2 taking BAR 47 to his flat.[118]

157 We are satisfied that these events occurred, and that they should not have. We consider that management at Macedon were at fault in not taking steps to investigate whether an inappropriately close relationship was developing between a staff member and a teenage girl resident in the home. Whether or not anything untoward in other respects occurred between BAR 2 and BAR 47 (as to which we express no conclusion), **the failure to prevent this relationship developing, and then to put a stop to it, represented a systemic failing on the part of the management at Macedon to ensure proper standards of professional behaviour on the part of BAR 2**.

The Ruddock Report

158 When the trial judge sentenced BAR 1 and BAR 2 he made a number of critical observations as to how Macedon was run based on the evidence given during the trial, which had been clearly accepted by the jury. After the trial, and before the developments leading up to and during the Court of Appeal hearing, Barnardo's arranged for a senior officer at its headquarters in Barkingside in Essex to carry out an investigation and report. Lynda Wilson explained that this was not intended to be an in-depth historical review of the allegations, but an examination of Barnardo's practices when viewed against the trial judge's remarks in order to see whether there were systems failures in Macedon during the time with which the trial was concerned, and to check Barnardo's current

116 Day 172, pp. 99 to 100.
117 See police report at BAR 4278 for other accounts to the same effect.
118 BAR 4282.

practices.[119] This report was prepared by Martin Ruddock. Whilst part of the process involved consideration of notes taken with the permission of the judge by Barnardo's staff during the trial, Ruddock also examined a number of the children's files.

159 The Ruddock Report was subject to trenchant criticism by BAR 14, who had not seen it before it was provided to him by the Inquiry. He described it as, "a rather shallow piece of work, somewhat partial in its scope, and certainly weak in the evidence".[120] "To me it was a crudely constructed set of conclusions without evidence".

160 Ruddock commented on a number of matters, in particular BAR 1's continued employment, and observed that in his view "... management failed to effectively review evidence from children's records and no doubt elsewhere to show something at Macedon was wrong". However, he immediately qualified that by continuing:

> "This comment is however made with hindsight and knowledge about abusive practice gained through numerous reviews over the last 20 years".[121]

161 A key conclusion, and one to which BAR 14 took particular exception, was contained in the following passage:

> "My hypothesis is that the level of incident, low staff moral [sic] political environment [letter by BAR 24][122] management failure and lack of strategic leadership left a staff group managing a level of chaos that inhibited reflective practice to identify and address what was going on".[123]

162 We do not consider it necessary to comment upon every detail of the Ruddock Report. We accept that to a significant degree it was influenced by hindsight. We also accept that between 1977 and 1981 Barnardo's senior staff in Northern Ireland engaged in detailed strategic planning that led to Macedon being replaced by the innovative and carefully planned Sharonmore Project. We do not consider that there was a lack of strategic leadership in Barnardo's at that time in that context.

119 Day 172, p.133.
120 Day 172, p.12.
121 BAR 056.
122 BAR 4242.
123 BAR 057.

163 However, we are satisfied that management practices at Macedon during the years 1977 to 1981 were deficient in a number of respects that give rise to systemic failings. As we have already indicated, we consider BAR 1 should not have been employed at Macedon. Her assaults, and the assaults of her two colleagues, on HIA 101 and her being allowed to frighten children by telling ghost stories and the related matters should have been dealt with sooner and more robustly. The failure of BAR 24 to report BAR 3's behaviour to his superiors was a further example of an unacceptable approach. All of these failings contributed towards creating, or perpetuating, risks of abuse to children, whether they were in care of Barnardo's in Macedon or elsewhere.

164 Barnardo's have stated that the Ruddock report meant "Barnardo's accepted that when the decision was made to close Macedon, management focus shifted to the development of the new Sharonmore service. This shift in service, it was further accepted, had detrimental implications for the robustness of the service to be closed".[124]

165 We are satisfied the failings we have identified occurred because of poor management at Macedon, something that reflects on the leadership exercised by Barnardo's staff both in Macedon and at a higher level in Northern Ireland, possibly because oversight of Macedon by more senior staff was reduced due to the attention devoted to bringing the Sharonmore Project into being and to completion, as well as achieving a smooth transition from Macedon to Sharonmore. **We regard the poor management at Macedon and of Macedon during BAR 1's time there as a systemic failing by Barnardo's.**

BAR 52

166 The fourth person to be investigated by the police during the Macedon Inquiry was BAR 52 who was employed as a gardener or handyman at Macedon for some nine months between November 1973 and August 1974. BAR 55 (who did not apply to the Inquiry) was at Macedon for most of the time between 1969, (when she was aged six or seven), and 1976, when she was sixteen. In 2000 she described to the police how she had been in the handyman's shed when she was twelve, and how he came up behind her while she was standing at the work bench, put his hands on the bench on either side of her, rubbed himself against the back of her

124 BAR 21087.

legs, and rubbed his hand on her leg on top of her school uniform skirt. Someone called his name and he moved away. Although she thought she told another girl about this, it would seem that she did not report the incident to anyone in authority.

167 When questioned by the police in 2000, he was 80 and the alleged events had occurred more than 26 years before. He denied allowing children into his workshop.[125] As the investigating officer commented,[126] the allegations were uncorroborated. Taking into account BAR 52's age and the passage of time the DPP directed no prosecution.[127]

168 BAR 52 was the brother-in-law of the then superintendent BAR 24. This appears to have been a "one-off" episode. Although there was one other allegation, which may have related to BAR 52, this was not pursued by the complainant and there appears to be no other allegations relating to him, whether at Macedon or elsewhere. Given the nature of his job as a grounds-man/handyman, it is unlikely that at that time in 1973 and 1974 the type of vetting which is now regarded as appropriate would have been considered usual for such a post. In those circumstances we do not consider that there is any evidence of a systemic failing on the part of Barnardo's in relation to these events.

Staffing

169 Apart from the suitability of BAR 1 to work at Macedon and Sharonmore, which we have already considered, among the criticisms made of Barnardo's by the trial judge when sentencing BAR 1 and BAR 2 was that "Staff had no or very basic qualifications and seem to have been given far too much unsupervised responsibility". We have the advantage of having received a great deal of evidence from all quarters about the level of qualifications and quality of staff during the post Second World War period in many more homes in the statutory and voluntary sectors of residential childcare in Northern Ireland than just the limited period at the Barnardo's homes at Macedon and Sharonmore that were examined during the trial.

170 That evidence, and the experience of those members of the panel with many years experience of the position elsewhere in the United Kingdom, leaves us in no doubt that in the early 1970s all residential institutions

125 BAR 5109.
126 BAR 4354.
127 BAR 4020.

for children still had to rely to a very significant degree on staff who were either unqualified, or had only basic qualifications, in residential childcare. There was a limited number of professionally qualified staff in the childcare sector generally at that time, something that the Ministry of Home Affairs had recognised as early as the 1950s needed to be improved.

171 Over many years the Ministry encouraged both the voluntary and statutory sectors to send staff on training courses and supported this by providing the necessary finance to pay replacement staff while staff were absent on training courses in England. From the late 1960s various training courses were provided by the Rupert Stanley College in Belfast on both a full-time and day-release basis. However, as BAR 14 pointed out in his evidence,[128] the voluntary sector had difficulty in retaining residential staff in the 1970s as the statutory sector offered more attractive working conditions, such as shorter hours and better pay.

172 It was only after the Hughes Inquiry had drawn attention to these difficulties in its report that a real improvement in the position in the residential childcare sector was achieved, and to such an extent that by the end of our Terms of Reference in 1995 the position in Northern Ireland was considerably ahead of the rest of England and Wales in this respect.

173 Although we have found systemic failings on the part of Barnardo's in relation to their employment of BAR 1 and in their treatment of the allegations against BAR 3, we consider that if anything, Barnardo's were better than other institutions in the voluntary sector in Northern Ireland in the quality of staff they employed. In her evidence Dr Harrison said that when she joined Barnardo's in 1976 its policy was to recruit staff with at least the minimum qualification, and her impression at that time was that there was a much higher number of staff with the basic qualification than maybe existed in statutory homes at that stage.[129]

174 Her recollection is in accordance with the evidence given to the Hughes Inquiry by BAR 79 (then the Divisional Director of Barnardo's for Ireland), and Barnardo's written submission to the Hughes Inquiry. BAR 79 emphasised that traditionally, Barnardo's put a lot of emphasis on staff development and training, and had its own training courses before nationally available courses became available from 1948 onwards.[130]

128 Day 171, p.34.
129 Day 172, pp. 42 and 46 to 48.
130 BAR 22026.

It also paid qualified staff more than their equivalents in the statutory sector so that they could attract and retain qualified staff.[131] As part of this approach, in 1979 Barnardo's decided to pay residential social workers the same as field social workers.[132]

175 BAR 79 pointed out that in its report of its 1983 inspection of Sharonmore the Social Work Advisory Group (SWAG) expressed the view that Sharonmore had :

> "...probably the best qualified group in a home in the Province. [And] overall, out of 120 social work staff in the division [that is for the whole of the island of Ireland] we have got 64 with an approved qualification by the Central Council for Education and Training in Social Work, and 34 staff with either the Certificate in Social Service, which is part-job related training, or another allied qualification in teaching or in youth work."[133]

176 We are satisfied that Barnardo's made every effort to recruit suitably qualified staff, and although we have found it to be guilty of a systemic failing in the specific case of BAR 1, we are satisfied there was not a general systemic failing in Barnardo's recruitment of staff. From the documents we have seen we are satisfied that Barnardo's had many excellent policies, systems, and procedures, and went to considerable lengths to disseminate these by regular visits by senior staff from Headquarters, individual supervision of staff and staff meetings. We recognise that in many respects Barnardo's were amongst the leading exponents in the United Kingdom in the demanding field of residential childcare for very difficult children.

Inspections

177 As in some other modules, the DHSSPS were unable to find reports of inspections of Macedon by inspectors from the Ministry of Home Affairs due to the normal process of review and destruction of old files. However, there is no reason to believe that such inspections were not carried out as we know they were in other institutions, and that is borne out by the evidence of BAR 14 who was aware of inspections by Miss Forrest and Miss Hill of Barnardo's in the 1970s.[134]

131 BAR 22026.
132 BAR 22054.
133 BAR 22026.
134 Day 171, 2015 at p.33.

178 BAR 14 told the Inquiry that in his eight years with Barnardo's he never met a SWAG inspector in his professional capacity, although he was aware of informal visits, it remains the position that SWAG did not carry out any formal inspections in the mid-1970s for reasons we address in Chapter 2, **but the failure by SWAG to carry out formal inspections of Macedon in the 1970s was a systemic failing on its part**.

Compliance with the Visiting Committee requirement of the Voluntary Homes Regulations

179 BAR 14 explained that although Barnardo's Council in Essex had ultimate responsibility, a considerable amount of authority was delegated to divisional heads. Because there was no visiting committee in the Barnardo's structure in Northern Ireland this meant that the Divisional Director in Northern Ireland in turn delegated the responsibility for regular visiting to the Assistant Divisional Director (the ADD) in the divisional headquarters. The ADD was answerable to the Divisional Director, and visited each residential home on a monthly basis and prepared a detailed report.[135] In addition, there were regular meetings of the superintendents and deputy heads of all the homes, which were properly minuted and matters of day-to-day administration and concern discussed, as can be seen from minutes produced to the Inquiry, such as those for the superintendents held on 8 September 1978.[136]

180 We consider that these arrangements meant that the Divisional Director for Ireland was the "administering authority" within the meaning of the 1975 Voluntary Homes Regulations, and that the visits by the ADD fulfilled the requirement under the Regulations for monthly visits.

181 The Hughes Inquiry received considerable detail from BAR 14 about the frequency of visits to Macedon and Sharonmore by the ADD during the period relating to the sexual assaults suffered by BAR 44, and Barnardo's requirements for regular written pro forma reports to be submitted to the ADD by the superintendent. It concluded at 11.20 of its report[137] that:

> "As we have said in earlier chapters, we consider the reporting activity to be of secondary importance to the actual visits, and we accept that BAR 111 [the ADD at the relevant time] did visit the Project [Sharonmore] on a regular basis and that monitoring was continuous

135 Day 171, 2015 pp. 16 to 19.
136 BAR 26075/6.
137 BAR 22012

and well-directed. Nevertheless, we consider Barnardo's record on reporting to have been less than entirely satisfactory in so far as it fell short of full compliance with the letter of the 1975 Regulations. Nevertheless, this had no relevance to the isolated offence against [BAR 4]".

182 We are satisfied that these arrangements provided a very high level of external oversight of the day-to-day working of Macedon and Sharonmore, oversight which amply complied with the spirit, if not perhaps the letter, of the Voluntary Homes Regulations.

Conclusions

183 We are satisfied that Barnardo's and the DHSS were responsible for the following systemic failings in relation to Macedon.

Barnardo's

184 **The failure to detect the bizarre behaviour of BAR 3, and then to take appropriate action, were systemic failures because they demonstrated a lack of knowledge of what was happening among the staff on the part of management at Macedon.**

185 **We consider the amount of unsupervised access by BAR 4 to HIA 216, and the failure of Barnardo's to inform the EHSSB that this access was taking place, represented systemic failures by Barnardo's to provide proper childcare.**

186 **There were several systemic failings in the way in which the allegations about BAR 3 were handled by Barnardo's staff at Macedon:**

- **They were not reported for some months by BAR 8 to BAR 24.**
- **A deliberate decision was made by BAR 24 not to report the full facts to his superiors or to anyone else.**
- **BAR 75 does not seem to have reported the remark made to him by BAR 47 that BAR 3 was a "real fruity boy" to his superiors at Barnardo's.[138]**

138 BAR 8619

187 **The reluctance on the part of some Barnardo's staff in Northern Ireland in the 1980s to report allegations about staff to the proper authorities was a systemic failing.**

188 **The manner in which the relationship between HIA 516 and BAR 12 was allowed to develop, and the length of time for which it was allowed to continue, represented systemic failures by Barnardo's to ensure proper childcare of HIA 516.**

189 **The 'wooden spoon' episode, and the way it was ultimately dealt with, represented a number of systemic failings on the part of Barnardo's:**

- **The three staff who struck HIA 101 acted in breach of Barnardo's policy prohibiting the use of any implement by way of corporal punishment.**
- **That each resorted to the use of a spoon in such an impulsive fashion suggests this may well have not been the only occasion that staff resorted to a wooden spoon to administer minor corporal punishment.**
- **To admonish the three staff, and to place a note on each of their personal files, was an inadequate and inappropriate response. The proper course to have taken at that time would have been for each to have received a formal written warning.**

190 **The way in which BAR 1 was allowed to frighten children with ghost stories and the 'evil eye' practice, and that it went unreported and/or undiscovered for several years by senior managers responsible for the home represented a failure by Barnardo's to exercise proper supervision.**

191 **BAR 1's bathing of male children who were of an age when they should have been left completely to bath themselves was an unacceptable practice which should not have been allowed to occur. That it was allowed was due to inadequate supervision of BAR 1 by management at Macedon, and amounted to a systemic failing.**

192 **We agree that the failure of Barnardo's management to investigate the nature of Mains' connection with BAR 1 and Macedon represented a systemic failing on the part of Barnardo's.**

193 **The failure to prevent the relationship between BAR 2 and BAR 47 developing, and then to put a stop to it, represented a systemic failing on the part of the management at Macedon to ensure proper standards of professional behaviour on the part of BAR 2.**

194 **BAR 1 should not have been retained as an employee for several years, let alone promoted, when it was clear that she was unsatisfactory in the manner that we have described.**

195 **BAR 1 had shown herself to be a completely unsatisfactory employee to be placed in the care of children for a considerable period of time before she finally resigned and Barnardo's failure to terminate her employment at an earlier stage represented a systemic failing to ensure that suitable staff were in place to look after the children in Barnardo's care.**

196 **There was poor management at, and of, Macedon during BAR 1's employment.**

197 **There was a failure on the part of the management at Macedon to ensure proper standards of professional behaviour on the part of BAR 2.**

The DHSS

198 **The failure by SWAG to carry out formal inspections of Macedon in the 1970s.**

Chapter 20:

Module 9 – Manor House Home, Lisburn

Introduction

1 The Inquiry devoted Module 9 to the examination of Manor House Home (Manor House), a children's home in Lisburn, County Antrim. Manor House was run by The Society for the Irish Church Missions to the Roman Catholics, which was a mission agency associated with the Church of Ireland. It was founded in March 1849 with the aim of converting members of the Roman Catholic faith in Ireland to Protestantism. The headquarters of the organisation was in London and it was managed by a General Committee made up of clergy from the Church of Ireland and the Church of England, which at that time were one Church under the Act of Union of 1800. A Northern Committee composed of lay and clerical representatives of the Church of Ireland and the London Committee was based in Belfast. The organisation is now known as the Irish Church Missions (ICM) and the abbreviation of that title will be used in this chapter. The ICM is now a registered charity concerned with the encouragement of gospel growth in Ireland.

2 The Inquiry devoted four sitting days to this module commencing on 5 January 2016 and finishing on 8 January 2016. We received complaints about Manor House from six former residents. We heard evidence from two of these witnesses, HIA 346 and HIA 341 on 4 September 2014, as part of Module 2 of the Inquiry which dealt with child migrant schemes. During Module 9 we heard three witnesses, HIA 365, HIA 290 and HIA 366 and a summary of the statement of HIA 289 who was unable to attend in person for health reasons.

3 HIA 354, who gave evidence on 3 September 2014, during Module 2 of the Inquiry, referred to a brief stay he had in Manor House in November 1950 prior to being sent to Australia. HIA 354's only memories of Manor House were of being taught hymns and being given a bath and new clothes prior to his departure to Australia. He had no complaints about how he was treated in the home.[1]

4 In addition to the evidence from witnesses, we considered information provided by the ICM about the establishment and operation of Manor House and its written responses to the statements provided by witnesses about the home. Reverend Edmund Coulter, the current Superintendent of ICM and Reverend Courtney, a retired Church of Ireland clergyman gave

1 MNH 033/4.

evidence in person. Dr Hilary Harrison provided a written statement and gave evidence in person on behalf of the Department of Health, Social Services and Public Safety (DHSSPS). Fionnuala McAndrew, Director of Social Care and Children's Services, Health and Social Care Board provided a statement and exhibits on behalf of the Health and Social Care Board (HSCB) and the HSCB also provided written responses to the statements from former resident witnesses. We also examined police material about investigations into allegations of peer sexual abuse in Manor House, sexual abuse of a resident by an adult visitor to the home and sexual abuse of another resident by a man unconnected to the home.

5 We spent some time considering the initial funding and inspection of the home by the Ministry of Home Affairs (MoHA). This was because the MoHA's engagement with Manor House provided the only example we are aware of where the MoHA contemplated removing registration granted to a voluntary children's home under the Children and Young Persons Act (Northern Ireland) 1968.

6 We appreciated the contemporaneous records and documentation provided by ICM, DHSSPS, the HSCB and the police, which greatly assisted our understanding of Manor House.

The Establishment of Manor House

7 In 1925, Miss Louisa Stannus, who was running a home for orphaned and disadvantaged children in her Manor House estate in Lisburn, made a proposal to the ICM that she would donate her home to the organisation if it would undertake to continue to run it as a children's home.[2] Following negotiations between Miss Stannus and the ICM about the terms of the donation the ICM took over the property and formally opened it as a children's home in November 1927.[3]

8 From the beginning, the funding of the home proved to be difficult for the ICM, and only seven months after it opened the General Committee of the ICM was considering closing the home.[4] However, it decided to allow time for a special appeal for the home to be launched in Northern Ireland and to use a legacy of £500 it had received to support the home. Despite these measures, the financial difficulties continued to the extent that by

2 MNH 2323.
3 MNH 2324.
4 MNH 2324.

December 1929 the children in the home had been moved to Dublin and the home was temporarily closed.[5]

9 In January 1930, the General Committee received representations from a Dr Peate, deploring the closure of the home and indicating that he and others felt that sufficient funds could be raised locally to support the home and warrant it being re-opened. The Financial Secretary of the General Committee was instructed to respond to Dr Peate and explain that while his views were appreciated there were "many difficulties in the way of re-opening the home".[6]

10 An important consideration for the ICM at this time was its obligations under the terms of the Trust it had agreed with Miss Stannus for the transfer of the property. It was also dealing with threats from Miss Stannus that she would sue ICM for compensation for monies she spent on repairs to the home after its closure.[7] The ICM sought advice from the Attorney General of Northern Ireland about the terms of the Trust, and legal advice about its position in relation to Miss Stannus's claims. The minutes of the General Committee dated 27 November 1930 recorded that the Rev T.C. Hammond had been advised by Mr Hector Hughes KC that in the circumstances the best solution would be for the ICM's Northern Committee to take over and re-open the home, which would mean the Trust would be fulfilled and in turn this would deprive Miss Stannus of any claim.[8] This advice was accepted and the General Committee agreed to provide the £200 required for repairs to Manor House, but only on the "understanding that the Northern Committee took over the entire liability of running the Home".[9] Given the General Committee's understanding of the financial difficulties experienced in maintaining and running the home we consider it was irresponsible of it to decide to re-open the home in order to avoid further legal action by Miss Stannus and then to allocate very limited funding for essential repairs and pass full responsibility for the home to its Northern Committee. **We consider this irresponsible approach amounted to a systemic failing by the General Committee of the ICM to ensure the home provided proper care**.

5 MNH 2325.
6 MNH 2326.
7 MNH 2326/7.
8 MNH 2326.
9 MNH 2326.

11 The Northern Committee agreed to this arrangement and following a court case in Belfast about the terms of the Trust it was ruled that the ICM should establish a local Management Committee for Manor House. The Management Committee was duly established. It was elected by the Northern Committee and approved by the General Committee of the ICM which indicates that the General Committee continued to have a formal role in the governance of the home. The Management Committee was comprised of clergy and lay people from the Church of Ireland, some of whom were local to the Lisburn area.[10]

12 The home reopened in 1932, and it is clear from minutes of meetings at that time that the Management Committee was almost solely responsible for securing funding for the home. The General Committee of ICM limited its contribution to a sum of not more than £52 per annum to help with the costs of paying the salary of the matron of the home.[11] As the majority of children admitted to the home were private placements, generally on the application of a local clergyman,[12] their care was not funded by Welfare Authorities. Limited financial contributions were received from the families of some of the children resident in the home.[13]

13 In order to raise funds, the Management Committee organised a variety of appeals in local papers and flag days and rented out some of the land surrounding the home. It also employed two ladies to raise and collect funds for the home and this was an important source of income.[14]

14 These funding arrangements appear to have been adequate for a number of years. For example, the minutes of a Management Committee meeting held in February 1947 recorded that the finances of the home for the year ending 31 December 1946 were most satisfactory.[15] However, by October 1951 the financial situation had taken a significant downturn on account of the illness and consequent resignation of the principal collector due to ill health.

15 At its meeting on 13 November 1951 the Management Committee recorded that debts were outstanding and accounts had not been paid for two months, and agreed that a statement of its accounts should be sent to

10 MNH 2328.
11 MNH 2327.
12 for example, MNH 3194.
13 MNH 2031.
14 MNH 2031.
15 MNH 3218.

the General Committee of the ICM. This decision suggests that although the General Committee was responsible for approving the appointment of the Management Committee it did not extend its governance to regular monitoring of the financial state of the homes. This was despite the financial difficulties it had experienced in funding the home. The Management Committee estimated that £2,000 was required annually to maintain the home, and recognised that in order to keep the finances of the home in a satisfactory state "a steady reliable and adequate income was necessary".[16]

16 There is evidence of contact between the home and government departments in 1945 in relation to a proposal to build a crèche facility for children. The minutes of the Management Committee meeting held on 23 February 1945 refer to a meeting being arranged with the Prime Minister with a view to obtaining the necessary materials for the new building.[17] There is no evidence that inspections and visits to voluntary children's homes which were provided for by Section 25 of the Children's Act 1908[18] were made to Manor House. The DHSSPS has indicated that it is likely such visits were made to the home during the period 1927 to 1950 since the Ministry of Home Affairs (MoHA) employed children's inspectors from 1922,[19] but files that would have recorded such visits are no longer in existence.

17 However, whatever the position was prior to 1950, the passing of the Children and Young Persons Act (Northern Ireland) 1950, which required for the first time all voluntary children's homes to be registered by the MoHA, meant that Manor House came to the attention of officials from that Ministry.

Registration Process

18 The Management Committee first applied to have Manor House approved as an adoption agency and MoHA inspectors, Miss Forrest and Miss Harrison, visited the home in June 1950 in connection with that application. The inspectors met with Mrs Bannister of the Management Committee and the matron of the home, Miss Scott. Miss Forrest's report of the visit, dated

16 MNH 3309.
17 MNH 2481.
18 MNH 300.
19 MNH 15032.

8 June 1950,[20] record these ladies expressing some ambivalence about the application to become an adoption agency because the home did not have outreach workers and the matron already "had her hands full with her own work: 20 children (17 at school, 3 toddlers)". The staffing was detailed as matron, assistant matron, a nursery assistant aged sixteen years and a cook who all lived in the home and an unspecified number of domestic staff who were not resident in the home.[21]

19 Miss Forrest recorded her concern that the Management Committee was not aware the home had to be registered as a voluntary children's home, and appeared to think that such registration was linked to applications to the MoHA for funding. She described the home as very clean but shabby, noted decorating work was underway, and concluded that the home "seemed generally to be run on good lines, handicapped by lack of money".[22] At the end of her report she noted that her colleague, Mr Wilde, told her after her visit to the home that the DMO, whom we take to be the Divisional Medical Officer, thought the health of the children from the home who attended school was "not up to scratch".[23]

20 The MoHA received an application on 22 June 1950 for Manor House to be registered as a children's home,[24] with a covering letter asking for information about how the home might apply for a grant. The application form stated that the home could accommodate up to twenty-two children and that the nineteen children resident in the home at that time were being cared for by five female staff.

21 A letter dated 29 June 1950 was sent from the MoHA to the Management Committee to confirm Manor House had been granted registration and that the Ministry would consider applications for funding to assist the improvement of premises or equipment and the securing of qualified staff. The letter also explained that the MoHA intended to issue regulations for the conduct of children's homes, but that its powers to inspect children's homes would be put in force straight away and that Inspectors would carry out their first inspections within the next few weeks.[25]

20 MNH 2939-2941.
21 MNH 2939.
22 MNH 2940.
23 MNH 2941.
24 MNH 2933.
25 MNH 2927.

22 Despite this indication that an inspection was imminent no inspection took place and we found no record of any other visit by MoHA officials to the home until February 1953. The only indication of any contact between the home and MoHA from June 1950 to August 1952 is a reference in a letter dated 11 August 1952 from Mrs Bannister, who was by then the chairman of the Management Committee, to the then Minister of Home Affairs, Brian Maginess QC MP, which suggests the MoHA played a role in arranging for the Fire Authority to inspect Manor House.[26] However, it seems likely that this was a general arrangement put in place for all voluntary children's homes rather than a specific measure for Manor House.

23 Mrs Bannister wrote to Mr Maginess to ask for a grant to assist Manor House to implement the recommendations of the Fire Authority.[27] She explained that the home was in a financially embarrassed state because it had spent around £1,000 on repairs in the previous five years and its running costs had increased. A letter was sent by return under the name of the Minister indicating that it might not be possible to provide a grant as the Government was precluded from making contributions to any religious body.[28] However, this matter was quickly resolved, and the next day a further letter was sent stating that a grant might be possible and providing guidance about the conditions for grant aid.[29]

24 On 18 November 1952 the Management Committee submitted an application for funding for a grant of £1,000 towards the costs of meeting the Fire Authority's requirements and providing a new sewer and a playground.[30] In the supporting documentation sent with the letter, the chairman and the treasurer of the Management Committee confirmed that the home had a debt of over £600 due to the bank. Representatives from the Management Committee met with officials at Stormont on 7 January 1953 to discuss grant conditions. In a note of that meeting an unidentifiable official raised concern about whether the Management Committee would be able to fund the extensive repairs to the home that appeared necessary, and suggested that the opinion of an architect should be sought before a grant was made.[31]

26 MNH 2925.
27 MNH 2925.
28 MNH 2924.
29 MNH 2923.
30 MNH 2919.
31 MNH 2910.

25 Six days after that meeting the MoHA received notification from Antrim Welfare Authority that it had received an adverse report on Manor House, and officials decided to delay a planned inspection of the home until the matter could be investigated.[32] Miss Forrest spoke to the relevant Welfare Officer, and recorded on 4 February 1953[33] that the adverse report was about a rumour that children were being beaten in the home, but the mother of the children concerned had clarified that her children's complaint had been that the food in the home was dull and insufficient and that she understood it had improved. Miss Forrest also recorded the Welfare Officer's concern about inadequate staffing in the home, and how on one visit he had found a senior girl in charge.

26 On 6 February 1953, Mr Jackson a MoHA official, Miss Forrest and Mr Gibbs, an architect from the Ministry of Health and Local Government, visited the home to assess its condition and consider whether the Ministry would be justified in making a grant.

27 Miss Forrest and Mr Jackson both produced reports of the visit[34] and recorded significant concerns about the conditions they found in the home. These included dirty, untidy and cold rooms in need of renovation, and inadequate and unsuitable toilet and bathing facilities for the children. On a positive note, Miss Forrest recorded that children who wet the bed, who had previously been sleeping "in an awful little room in the basement quite away from everyone", had been brought back to sleep with the other children following MoHA officials protesting to Mrs Bannister about the previous sleeping arrangements when she met with officials in Stormont.[35]

28 Mr Jackson noted, "The building and equipment conveyed a most depressing impression of dilapidation and dirt", and commented that given the state of the home "the staff is insufficient, incompetent or lazy".[36] Miss Forrest also commented on the insufficient, untrained and inexperienced staff and the poor relations between the matron and her assistant.[37]

29 The inspectors found the children supervised by a senior girl in a room heated by one stove which the children were seated some distance from. They found all the staff in the kitchen, which they commented was the one

32 MNH 2908.
33 MNH 2908.
34 MNH 2904 and MNH 2894.
35 MNH 2905.
36 MNH 2894.
37 MNH 2904.

warm room in the house. Although Mr Jackson found the children to have pleasant manners and to be reasonably well nourished and clad, Miss Forrest recorded:

> "...the Children, although not unhappy looking, seemed dull and I thought them unresponsive and not so much ill-mannered as unmannered. They are just untrained".[38]

30 Mr Jackson recorded concerns about the ability and experience of Mrs Bannister and her Management Committee colleague, Mr McAdoo, and questioned whether they would be able to raise the funds that the home clearly needed. Miss Forrest commented that Mrs Bannister was unaware of the Regulations the MoHA had issued about the conduct of children's homes and asked for a copy to be sent to her.

31 Mr Jackson concluded:

> "So, far from recommending a Government grant in this case, I would suggest that we should seriously consider the transfer of the children to the care of the Welfare Authority if the Irish Church Missions cannot rise to the occasion within a reasonable time".[39]

We noted that there is no record of the MoHA advising the Management Committee to ask the Welfare Authorities to fund the care of the children from their areas who had been placed in the home through private arrangements.

32 Mr Gibb, the architect, also reported on the visit[40] and echoed his colleagues' concerns about the dilapidated state of the home. In particular, he pointed out that the wooden fire escape appeared very insecure and highly dangerous.

33 Although the letter confirming the registration of the home indicated that the Ministry's power to inspect voluntary homes would be put in force straight away, and that Inspectors would carry out their first inspection visit within the next few weeks, there was a delay of two years and seven months before MoHA officials visited the home. We recognise that MoHA officials would have been busy at that time implementing a new registration process and developing statutory regulations for the conduct of children's homes. However, this delay has to be considered within the context of Miss Forrest's initial observations in June 1950 about the state of the home

38 MNH 2904.
39 MNH 2907.
40 MNH 2897.

and her reference to the Divisional Medical Officer's view about the health of the children. Also, it is clear from internal MoHA documentation that officials had reservations about the content and tone of the information provided in the application for the homes to be registered, which a senior civil servant recorded "scarcely suggested a hard headed and businesslike committee running a well organised home".[41]

34 We consider that these concerns should have warranted an earlier inspection. By the time Miss Forrest returned to the home on 6 February 1953 the conditions for the children had deteriorated significantly. Earlier inspection visits could have enabled the poor conditions for the children in the home to be identified and addressed sooner. **Therefore, we find the lack of inspection of the home for a period of over two and a half years following initial registration to be a systemic failing by the MoHA to ensure the home provided proper care.**

35 **Although the reports of the MoHA inspectors described children who appear content and well nourished we consider the general state of dilapidation in the home, the inadequate sleeping, toilet and washing facilities for the children, the poor heating and the low staffing levels amount to a systemic failing by the Management Committee at that time to ensure the home provided proper care**.

36 Following a report in the *Northern Whig* newspaper on 10 February 1953 regarding the seeking of additional funds by the ICM that made reference to a visit by the ICM Superintendent, Reverend T H Horan, Miss Forrest contacted Mrs. Bannister to ask if she had alerted Reverend Horan to the situation in the home. Miss Forrest recorded that Mrs. Bannister told her she had some general conversation with the Superintendent, but did not tell him about the MoHA visit or the inspectors' criticisms. Mrs. Bannister informed Miss Forrest that the Management Committee had met, and that all the members were confident that they "can or should carry on the home and that they can bring it up to scratch". She also informed Miss Forrest that the matron was leaving the employment of the home the following day.[42]

37 Miss Forrest visited the home again on 12 February 1953, this time with Dr Simpson.[43] Dr Simpson recorded in his note of the visit that Miss

41 MNH 2733.
42 MNH 2898.
43 MNH 2877.

Forrest found that the home had been cleaned since her last visit and new bed clothes had been purchased. Dr Simpson noted that the staffing had reduced to one assistant matron and a live-in domestic, and pointed out that this level of staffing was inadequate to care for fourteen children, some of whom were under five years. However, he was less pessimistic than his colleagues about the home, and suggested that given money and additional staff it would be possible to convert the premises into a satisfactory children's home.[44]

38 In a letter dated 10 February 1953, in support of the Management Committee's funding application, the Financial Secretary of the ICM, submitted the organisation's income and expenditure accounts for 1950/51 and 1951/52 to Mr Dunlop of the MoHA.[45] An unidentified MoHA official concluded the accounts showed that there was little prospect of financial assistance being made available to the home from ICM's headquarters.[46] He advised that the MoHA should:

> "have a heart to heart talk with the Committee at an early date and endeavour to make the members realise that it's not a Government grant they need so much as a series of schemes which would secure the home a much larger income".

We noted again that officials do not appear to have considered the possibility of advising the Management Committee to ask the welfare authorities to provide funding for the children from their areas that were resident in the home.

39 In March 1953 the Management Committee sent a report to the ICM Headquarters outlining the home's financial needs in respect of the premises, equipment, laundry, food, clothing and staff.[47] It concluded that it:

> "...was absolutely impossible for the Committee to obtain from voluntary subscriptions or by its own efforts the money required to continue the work of the Manor House Home".

40 In April 1953, the Management Committee wrote to MoHA enquiring about its grant application.[48] This resulted in a further meeting between

44 MNH 2877.
45 MNH 2878.
46 MNH 2875.
47 MNH 2856-2859.
48 MNH 2871.

the Management Committee and officials on 17 April 1953.[49] The MoHA's note of the meeting recorded that the Management Committee was considering appointing an architect to prepare estimates with a view to making a renewed grant application, and that officials had emphasised that before making any grant, the Ministry would:

> "...have to be satisfied that the finances of the organisation were such as would enable it to carry on its functions as regards general maintenance and management".[50]

41 Following this meeting three members of the Management Committee asked for a private meeting with officials which took place on 22 May 1953.[51] It was clear to officials from that meeting that there was a split in the Management Committee about the future of the home. Each of the three members who met the officials indicated that they favoured a transfer of the home to Antrim Welfare Authority.

42 Further to this meeting, officials met on 22 May 1953. They decided to send extracts from the inspectors' reports on Manor House to the Management Committee with a letter warning that the registration of the home would have to be withdrawn if the conditions were not made right within a reasonable period.[52] They also decided to send a copy of the correspondence to the ICM headquarters and agreed that Miss Forrest should pay a further visit to the home to monitor the situation.

43 In her overview report on the state of voluntary children's homes in Northern Ireland dated 28 April 1953,[53] Miss Forrest provided the following critique of Manor House:

> "Has been both poverty stricken in money and ideas for some time past. Insufficient staff of poor quality in recent times. Equipment and maintenance very poor. Some improvement in recent weeks but needs a large amount of money spent on eg floor-coverings, heating, beds, tables, chairs and play equipment. Attend outside schools".

44 Miss Forrest visited the home again on 22 May 1953 with a colleague, Mr Dunlop.[54] Although she found the house cleaner, and noted that some decorating had been done, her overall assessment was that "the state

49 MNH 2865-2869.
50 MNH 2866.
51 MNH 2855.
52 MNH 2855.
53 HIA 1462.
54 MNH 2852-2854.

of disorder and untidiness was appalling".[55] She noted that the children looked well and happy but that the sleeping, toilet and washing facilities for them remained unsatisfactory and their clothes were frayed and worn.

45 Mr. Dunlop also made a report of the visit and recorded his amazement at the conditions in the home. He concluded:

> "…in my opinion the home should be closed until it is put in order by the present organisation or taken over by some responsible body".[56]

46 A letter dated 8 June 1953 was sent from Mr O'Neill, Assistant Secretary, MoHA, to the Honorary Treasurer of the Manor House Committee,[57] and a copy was sent to the ICM headquarters.[58] Mr O'Neill recognised the efforts of the Management Committee, but pointed out that the Ministry could not maintain the registration of any home where the conditions were so unsatisfactory. He pointed out that as the registering authority the MoHA had the power to remove a voluntary home from the register where it appeared that the conduct of the home "was not in accordance with the regulations made or directions given…or is otherwise unsatisfactory."[59] Mr O'Neill concluded by stating:

> "Unless the Committee can assure the Ministry that immediate steps will be taken to bring the home up to the necessary standard, I am afraid the Ministry will have no alternative but to withdraw the home from the register".[60]

47 It is clear from internal MoHA documentation that the first draft of this letter was amended to make it "a more lengthy and sympathetic letter".[61] The initials on the note explaining the amendments are not clear but they appear to be WBM, which would suggest it was the then Minister of Home Affairs, William Brian Maginness QC MP, who wanted a more sympathetic approach to the Management Committee.

48 Mr Gurd, the Honorary Treasurer of the Management Committee sent a letter dated 10 June 1953, in response to Mr O'Neill's letter, in which he stated the Management Committee was going to meet on 19 June

55 MNH 2852.
56 MNH 2848.
57 MNH 2837/8.
58 MNH 2833.
59 Section 99(4) of the Children and Young Persons Act (Northern Ireland) 1950 (HIA 233).
60 MNH 2838.
61 MNH 2843.

1953 to consider the MoHA's concerns about the home.[62] The Financial Secretary of the ICM also responded on 10 June 1953 to inform the MoHA that the ICM could not offer any financial help to the local committee.[63] However, she followed this letter with a further letter to the MoHA dated 18 June 1953, in which she indicated that the ICM was "considering the possibility of reconstituting the Trust".[64]

49 It is clear from hand written comments on the copy of this second letter that MoHA officials had different views about what response should be made to the ICM. Mr O'Neill responded to the Financial Secretary's letter on 22 June 1953.[65] He pointed out that the meeting of the Management Committee which was due to take place on 19 June 1953 had been cancelled, and that in the circumstances the Ministry's intention was to give notice to the Management Committee that the Certificate of Registration would be withdrawn from 1 August 1953. He stated however:

> "If of course, subsequently the Committee is in a position to convince the Ministry that it is able to run the home satisfactorily and in accordance with the regulations, the Ministry will be only too pleased to renew the Certificate of Registration".

50 Mr O'Neill also wrote to the Management Committee on 22 June 1953.[66] He referred to the Committee's cancellation of its planned meeting on 19 June 1953 and pointed out that the Ministry could not continue to permit children to be accommodated in a home under such unsatisfactory conditions. A copy of the letter sent to the ICM headquarters about the planned removal of registration from the home from 1 August 1953 was attached for information.

51 Subsequently, Mr Gurd confirmed in a telephone call to a MoHA official, which appears from the handwritten note of the conversation to be a Mr Dunlop,[67] that the Dublin branch had "agreed that the only thing to do was to close the home immediately but that the certificate should be retained". Mr Dunlop recorded that he pointed out that it would be more satisfactory if the certificate was returned as this would avoid any chance of the home being reopened before they were in a position financially to

62 MNH 2831.
63 MNH 2830.
64 MNH 2828.
65 MNH 2824/5.
66 MNH 2826/7.
67 MNH 2820.

do so. However, on a further file note dated 24 June 1953[68] Mr Dunlop recorded that he advised Mr Gurd:

> "...that the Management Committee might like to consider asking the Ministry not to take any action in relation to its letter and that the committee would arrange to disperse the children, promise not to admit any more and to hold the Certificate until the Chairman returns when they could then consider what action they should take".[69]

52 Subsequently Mr Gurd wrote to the MoHA on 29 June 1953[70] to confirm that the Management Committee had resolved to close the home as soon as satisfactory arrangements could be made to receive the children elsewhere, and that no further children would be admitted. He also requested that the MoHA:

> "...take no further steps regarding withdrawal of registration as after these arrangements have been made, we will ask you to accept a voluntary surrender of our registration until such time as we are in a position to carry on again."[71]

53 The Financial Secretary of the ICM wrote to the MoHA on 2 July 1953[72] to confirm the intention to have the children in Manor House transferred to Mrs Smyly's Homes in Dublin. The ICM had a close association with these homes. She also stated:

> "...my Committee hopes within the next few months that it may be found possible to reconstitute the Manor House Home on a basis satisfactory to your Ministry."

54 In a handwritten annotation to this letter, a MoHA official commented, "... If our Children Act has done nothing else it has at least cleared out this dump!"[73]

55 By 9 July 1953, the ICM had appointed a new Management Committee for Manor House Home[74] and when Miss Forrest visited the home on 10 July 1953,[75] she found that all the children had been sent to homes in Dublin except one child who had been found an alternative placement by Fermanagh Welfare Authority.[76]

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68 MNH 2819.
69 MNH 2819.
70 MNH 2817.
71 MNH 2817.
72 MNH 2811.
73 MNH 2811.
74 MNH 2810.
75 MNH 2808.
76 MNH 2792.

56 Despite Mr Gurd's undertaking to surrender the Certificate of Registration the Management Committee did not do so and the MoHA took no action to require it to do so. Internal MoHA communications suggest that officials took this approach on the direction of the then Minister of Home Affairs, Mr Maginess. In a submission dated 1 September 1954[77] a MoHA official referred to the Minister's feeling at the time of the closure:

> "Our then Minister felt, however, that the local committee was a well-meaning and kindly body of persons (as, indeed, they certainly were) and that their failings were due to utter ineptitude rather than lack of good intentions; and he instructed the Division not to withdraw the Certificate in any way that would bring scandal upon them".[78]

57 A further reference on a file dated 23 November 1956[79] referred to Mr Maginess feeling that:

> "…the Institution was much too close to his own doorstep to be denied an opportunity of putting its affairs in order and perhaps starting a lease of renewed and more perfect life".

58 We noted a reference in a letter about Manor House sent from the MoHA to Welfare Committees in December 1957 that the MoHA had previously written to the Welfare Committees on 23 July 1953 to inform them that the use of Manor House had been discontinued temporarily as a voluntary home for children until further notice.[80]

59 In November 1953, MoHA received a letter from an architect acting on behalf of the Manor House Committee that enclosed plans and proposals for alterations and renovations to Manor House.[81] A MoHA architect, Mr Wright, inspected the home with Miss Forrest and Dr Simpson on 17 December 1953.[82]

60 This renewed engagement with the home prompted a series of discussions and correspondence within the MoHA about the approach that should be taken to the home and whether funding should be provided towards the costs of necessary renovations. It is clear that officials held different views. While some tended towards a sympathetic approach, others were of the view that as Manor House was no longer operating as a children's

77 MNH 2730.
78 MNH 2730.
79 MNH 2661.
80 MNH 2576.
81 MNH 2800.
82 MNH 2798/9.

home it was not eligible for a grant, and that in any case no grant should be considered until the new Management Committee showed it was able to meet the normal running costs of a children's home.

61 It is clear from the minutes of the Management Committee held on 21 September 1954[83] that the committee members were aware of the divergent views held by officials and sought a meeting with the then Minister of Home Affairs, Mr Hanna QC MP, to get definitive advice about whether the MoHA would be willing to grant funding for improvements to Manor House. The minutes recorded that the Secretary of the Management Committee had a frank discussion with Mr Hanna who indicated that if the Management Committee could raise £7,000 of the £12,000 it estimated was required for renovations and could show evidence of augmenting the regular income for the home considerably, the MoHA would be likely to give a grant in the region of £5,000.

62 A memo from Mr Hanna to officials, dated 7 September 1954,[84] indicates that he settled on the position he communicated to the Secretary of the Management Committee despite his reservations about the MoHA's handling of Manor House. In the memo he was critical that the Ministry had taken no action to withdraw the Certificate of Registration when the Management Committee failed to voluntarily surrender it as it had undertaken to do. He also pointed out that the Government architect's involvement in considering the plans for renovation of the home suggested that the MoHA "condoned the whole business". He expressed regret that he could not recall the registration, but accepted, as he had communicated to the Secretary of the Committee, that the Management Committee should be given the opportunity to secure necessary financing for the home.

63 A series of negotiations and meetings between representatives of the Management Committee and MoHA officials followed and culminated in the funding application for Manor House being referred in June 1956 to the Maconachie Committee.[85]

64 By letter dated 30 October 1956, Miss Maconachie informed the then Minister of Home Affairs, Mr W W B Topping QC MP, that her Committee had visited the home and scrutinised its accounts for the three years

83 MNH 3353.
84 MNH 2728.
85 The Maconachie Committee was established under the Children and Young Persons Act (Northern Ireland) 1950 to review grant applications from voluntary children's homes and training schools.

ending 31 December 1955 accounts and considered:

> "...the premises are now quite suitable for the reception and accommodation of 19 or 20 children, plus staff, and that the Management Committee is a responsible and conscientious body of persons".[86]

65 The Committee recommended that grant aid amounting to 70% of the approved expenditure over £10,000 incurred in the modernisation of the home should be awarded. Following further internal discussion in the MoHA about the terms of any grant and how and when it should be paid, given that Manor House was not currently operating as a children's home, the Minister approved the grant application. On 15 January 1957 the MoHA was notified of the Ministry of Finance's approval for a grant not to exceed £7,000 without the specific approval of the Ministry.[87]

66 On 15 October 1957 a letter from MoHA was sent to the Manor House Committee confirming this grant. We noted the reference in this letter to an advance grant of £2000 which had been paid to the home on 6 February 1957. The MoHA also sought information about the present position of the home in order that its inspectors could have an opportunity to inspect and report on the general suitability of the premises before the home was reopened. Inspectors visited the home in January 1957,[88] November 1957[89] and December 1957[90] to monitor progress. By 24 December 1957 the MoHA was in the position to write to the Secretary of the Management Committee to confirm that subject to adequate staffing arrangements being made the home was authorised to reopen for the reception of not more than twenty children.[91] The MoHA wrote to the Welfare Authorities on the same day to inform them that the home had been completely renovated and provided with appropriate staff and it was now reported by the Ministry's inspectors to be suitable for the accommodation of children.[92] We noted that this letter indicated that satisfactory staffing was in place in the home, while the letter sent on the same day to the Management Committee indicated that the reopening of the home was subject to adequate staffing arrangements being put in place.

86 MNH 2671.
87 MNH 2653.
88 MNH 2635.
89 MNH 2602.
90 MNH 2585.
91 MNH 2584.
92 MNH 2582/3.

Operation and Governance of Manor House from 1958 to 1984

67 When the home reopened under the management of the new committee it appears to have progressed well. The only extant records about admissions to Manor House cover the period November 1957 to December 1978. These show that, in contrast to the earlier years, generally over half of admissions were through the welfare authorities and then social services.[93] The fees received for these placements and funding raised through donations and special appeals and flag days[94] meant that the financial challenges the home had faced in the 1950s had lessened to the extent that by November 1962, the Management Committee was in a position to make loans of over £4,000 to the ICM headquarters.[95]

68 The minutes of the Management Committee show that it met regularly. Although it dealt with practical matters to do with the funding and maintenance of the home, it always received and discussed a general report about the health and progress of the children in the home, and concerned itself with the detail of arrangements for holidays and outings for the children. Committee members approved admissions to the home, and developed and agreed policies for the care and welfare of the children. For example, at its meeting on 18 January 1965 it agreed amendments to its rules about children receiving hospitality outside the home including approval for overnight stays away from the home.[96]

69 A staff sub-committee interviewed applicants for jobs and the Management Committee approved the appointment of staff and received progress reports about new appointments. The minutes show that there was a high turn-over of staff, particularly in 1962 and 1963, which was in part due to girls as young as fifteen and sixteen years being appointed as live-in care staff and leaving after short periods in the home,[97] but also due to poor relations between the matron, Miss Watson and some of her staff. The Management Committee recorded at its meeting on 15 October 1962 that it had to get to the root of the cause of the "major crisis" in staffing.[98] They subsequently interviewed staff who had resigned to find out their

93 MNH 159.
94 MNH 3521/2.
95 MNH 3514.
96 MNH 3630.
97 MNH 3535 and MNH 3538.
98 MNH 3511.

reasons for doing so and questioned Miss Watson about staff relations. The minutes of the meeting do not record any discussion of the effect the high turn-over of staff might be having on the children, but did record concern that supporters of the home and the general public would be wondering about the "almost continuous advertising for staff".[99] The tone of the minutes of subsequent meetings suggest that tensions developed between committee members and Miss Watson about staffing matters, and these culminated in Miss Watson's resignation in May 1963.

Administering Authority

70 The Management Committee was the Administering Authority of the home as defined in the Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland) 1952 (the Regulations). We will now consider the Management Committee's performance in this regard in relation to two key responsibilities it held as the Administering Authority: the appointment of an officer in charge and the appointment of a monthly visitor to the home.

71 Section 101 (1) of the Children and Young Persons Act 1950 dealt with regulations as to the conduct of voluntary homes and included provisions for the MoHA to be consulted about applicants for appointment to the post of person in charge of a home; prohibit the appointment of a particular person to such a post; and, receive required notice about any change of the person in charge of a home.[100] The Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland) 1952 (the Regulations) placed responsibility on the Administering Authority to appoint "a person to be in charge of the home" (Regulation 5(1)), and placed specific responsibilities on that post holder in relation to the maintenance of records such as the medical records of each child and records about the application of corporal punishment.[101] The Regulations specified that the person in charge of the home should ensure generally that order is maintained by his personal influence and understanding and that of his staff and that resort to corporal punishment should be avoided as far as possible. The detailed conditions for the application of corporal punishment included that it should only be administered by the person in charge of the home

99 MNH 3512.
100 HIA 236.
101 HIA 288.

or in his absence his duly authorised deputy.[102] In Manor House the title 'matron' was used for the person in charge of the home.

72 It was recorded in the minutes of the meeting of the Management Committee of 16 September 1963 that a letter dated 5 September 1963 had been received from the MoHA stating that inspectors were not content with the staffing position as neither matron nor her deputy were on duty when they visited.[103] The Management Committee decided that one of its members, Mrs Burns, would contact the MoHA and explain the situation had come about due to staff sickness and that a Miss Spencer had been in charge. There is no record of the outcome of Mrs Burns' discussions with the MoHA about the staffing situation.

73 The Management Committee also decided to contact MH 71 who was due to take up the post of Assistant Matron in October 1963, to let her know that she would be "in full charge for the time being".[104] The minutes of the next Management Committee meeting, which was held on 21 October 1963, recorded that MH 71 was in post and that since no suitable applicants had been found for the post of matron she had agreed to carry on in full charge for a longer period.[105]

74 At its next meeting on 18 November 1963 the Management Committee decided not to advertise for a matron at that time because of the cost of the unsuccessful advertising of the vacancy over the previous months and concern that frequent advertising of the vacancy would have "adverse effects".[106] At its meeting in February 1964 the Management Committee agreed that MH 71 should be given the title Acting Matron, "when referred to in the press or in public".[107] The minutes of the March 1964 meeting record that Miss Hill of the MoHA had telephoned about the vacant matron post, and that the Chairman had informed her of the difficulties experienced in filling the post and that the Committee had confidence in MH 71. There is no record of Miss Hill's response to this information or any further contact with her about this matter.

75 MH 71 continued in the post of Acting Matron, but in June 1964 informed the Management Committee that she would be resigning and leaving in

102 HIA 290.
103 MNH 3549.
104 MNH 3548.
105 MNH 3554.
106 MNH 3557.
107 MNH 3591.

December 1964 to commence child care training.[108] The Management Committee appointed MH 3 to the post of Assistant Matron in October 1964 and decided in June 1965 to appoint her as Matron of the home.[109]

76 We consider the delay of almost two years in appointing a matron was unacceptable, given that post holder's general responsibility for the day to day management of the home and specific responsibilities to ensure order was maintained in the home, that resort to corporal punishment was avoided as far as possible and where corporal punishment was deemed necessary to ensure it was administered in accordance the conditions set down in the Regulations.

77 It is also clear that the Management Committee did not ensure that the statutory regulation about monthly visiting was fully met. Regulation 4 (2) required:

> "The administering authority shall make arrangements for the home to be visited at least once in every month by a person who shall satisfy himself whether the home is conducted in the interests of the well-being of the children, and shall report to the administering authority upon his visit and shall enter in the record book referred to in the Schedule hereto his name and the date of his visit."[110]

78 The ICM told us that Rev Thompson, who was the Honorary Secretary of the Management Committee in the 1960s, visited the home regularly and met with the children and encouraged them to discuss any problems with him. However, there is no signed record of the dates of his visits and no record of Rev Thompson making a formal report on them to the Management Committee.

79 Mr Johnston, who was the Honorary Secretary to the Management Committee prior to the home's closure, gave evidence to The Committee of Inquiry into Children's Homes and Hostels (the Hughes Inquiry), and said he visited the home regularly, including for an hour and a half before each Committee meeting. He described spending time with the children, how he would investigate any complaints made by them and report substantiated complaints to the Management Committee[111] Mr Johnston stated to the Hughes Inquiry that he understood that through his visits to

108 MNH 3626.
109 MNH 3645.
110 HIA 288.
111 MNH 10148.

the home he was undertaking a statutory duty on behalf of the Committee but he accepted that his reporting of his visits was more informal than it should have been and that with hindsight it might have been better to provide a written report to the Committee.

80 We accept that arrangements were in place for the Honorary Secretary of the Management Committee to visit the home regularly, and meet with the children, but consider that these arrangements were not sufficiently formal to meet the statutory requirement for monthly visiting as set down in the Regulations. The DHSSPS accepted that MoHA should have checked that the monthly visiting requirement was being discharged.

81 **We consider that the Management Committee's delay in appointing an officer in charge during the period August 1963 to June 1965 and its failure to appoint a monthly visitor amounted to a systemic failing to meet statutory requirements and ensure the home provided proper care.**

82 **We consider the MoHA's failure to ensure that the Administering Authority met its statutory responsibilities to appoint a person in charge of the home during the period August 1963 to June 1965 and to make arrangements for monthly visiting amounted to a systemic failing to implement statutory requirements and ensure the home provided proper care.**

Inspections by the MoHA and the DHSS

83 There are references in the Manor House diary and Management Committee minutes to Miss Hill of the MoHA inspecting the home in September 1966 and September 1970. No further detail is available as the DHSSPS was unable to locate copies of Miss Hill's reports of these inspections. There also is evidence that Miss Forrest of the MoHA visited the home after 1969. Mr Johnston, the former Honorary Secretary of the Management Committee, told the Hughes Inquiry that Miss Forrest of the MoHA would have been a regular visitor to the home but that she would have met with the matron, MH 9, not with Committee members. MH 9 succeeded MH 3 as matron in October 1969.

84 Mr Johnston said he received feedback from MH 9 about these visits and MH 9 indicated that Miss Forrest "criticised quite a lot of the time".[112]

112 MNH 10162.

This lack of direct contact with the Management Committee meant that the MoHA was not in the position to check whether it was meeting its responsibilities as the Administering Authority for the home. **Given the history of Manor House, and the indication that Miss Forrest continued to be critical of the home, we consider the lack of more formal inspections at this time, and the MoHA's failure to raise Miss Forrest's criticisms with the Management Committee amounted to a systemic failing by the MoHA to ensure the home was providing proper care.**

85 **Equally we consider the Management Committee's failure to engage directly with Miss Forrest to find out more about her criticisms of the home amounted to a systemic failing on its part to ensure the home provided proper care.**

86 The lack of formal independent scrutiny of the home continued when the DHSS took over responsibility for the regulation of voluntary children's homes. The only indication we had of the DHSS's attitude to the home in the 1970s was that it was prepared to provide funding towards the costs of building new staff accommodation which would increase the accommodation available for children in the home. Minutes of a Management Committee meeting held at the start of 1978 (date not included)[113] record that the cost of the building work was £36,327, and £17,286 had been paid as a grant by the DHSS.

87 The use of the home by the Welfare Authorities in the 1960s and 1970s provides some indication that it was considered to be providing a satisfactory level of care. There was evidence of social workers regularly visiting children in the home, and, as we will consider later in this chapter, evidence of a senior social worker investigating complaints from a mother about the care her children were receiving in the home. However, as the HSCB pointed out in the statement it submitted for this Module, the primary purpose of social workers' visits was to monitor the individual needs of the children in the home that they were responsible for, and they would not, as a matter of course, have formed part of any overall quality assurance of the home.[114]

88 The DHSSPS was able to confirm from information provided to the Hughes Inquiry and other documentation available to it that the Social Work Advisory

113 MNH 10088.
114 MNH 333.

Group (SWAG) inspected the home in July 1978 and September 1981, that a follow-up visit to the 1981 inspection was made in December 1982, and that a social work adviser visited the home in January and August 1978, July 1979, probably July 1982 and definitely in September 1982.[115] Only the report of the 1981 inspection was available to the Inquiry. An internal memo from an inspector (Mr Walker) to Dr McCoy indicates that in addition to the formal inspection in 1981 he also "inspected" the home using a format for earlier inspections as a guide: four times in 1982; three times in 1983; and, four times in 1984.[116] There are no reports available of these visits or any action recommended by Mr Walker or taken by the home in the light of them. **We consider the continuing lack of formal inspections up until 1978 was unacceptable, particularly given the history of the home, and amounted to a systemic failing by the DHSS to ensure the home was providing proper care.**

89 The report of the inspection of the home carried out by SWAG on 28, 29 and 30 September 1981 provided us with a helpful analysis of the care regime in the home at that time.[117] The inspectors found seventeen children in residence whose ages ranged from three to sixteen years. Three of the children were in the care of the Health and Social Services Boards on a voluntary basis, and thirteen children were the subjects of Fit Persons Orders. There were five siblings groups, which accounted for fourteen of the children. The EHSSB was responsible for twelve of the children and the SHSSB for four of the children. There was only one resident who had been placed privately, and his admission had been arranged thirteen years before in 1968. Inspectors found that ten of the children had been resident in the home for from six to ten years, and expressed concern that greater efforts were not being made to return children to their families or their local communities.[118]

90 Inspectors commented on the absence of male care staff, the youthfulness of some care staff and that contact with outside agencies, including field social workers, was made only through the matron, MH 9. They expressed concern that individual files were not kept for each child, that junior staff did not have access to the files that were maintained and that the home did not receive up to date information about the regular reviews carried out on the children and their families by the Boards.

115 MNH 300.
116 MNH 2250-2251.
117 MNH 10194-10232.
118 MNH 10015.

91 Inspectors were critical of the use of a whistle to summon children to assemble outside the dining room before meals and, to assist the serving of meals, children being seated according to the portion size they ate. They also commented on meetings between children and their parents being confined to the hallway of the home, and children being woken to go to the toilet to prevent bed-wetting.

92 The inspectors found that staff were sensitive to the children's needs and sought to maintain a warm comfortable living environment and noted a mutual trust between the children and the staff. However, they observed staff spending time on domestic chores rather than interacting with the children and recommended that care staff should be given a clearly defined role which would enable them to work to address children's developmental needs.[119]

93 Mr Johnston told the Hughes Inquiry that as a result of this recommendation a maximum amount of time for care staff to spend on domestic chores was introduced, and that staff were pleased with the new arrangements as it meant they could spend more time with the children. He explained that some members of the Management Committee were surprised at this matter being raised by Inspectors, and queried what else staff would be doing if they were not engaged in domestic tasks. Mr Johnston accepted this indicated that some members of the Management Committee were not sufficiently modern in their approach to child care.[120]

94 The inspectors recorded their surprise at finding that the matron had not been consulted about, or given sight of, policy documents provided to SWAG by the Management Committee prior to the inspection, including the statement of the aims and objectives of the home. They pointed out that there was a need for a clearer distinction between the roles of the matron and the Management Committee, and more recognition of the matron's responsibility for professional work of the home.[121]

95 Inspectors commented on the drop in admissions to the home and suggested that, given the trend towards older children with more difficult behaviour being admitted to care, the home would have to be re-organised and the attitudes and assumptions of staff adjusted so that their capacity to cope with more disturbed children could be improved.

119 MNH 10036.
120 MNH 10155.
121 MNH 10224.

They also suggested that there needed to be more emphasis on working effectively in the short term on behalf of children with a view towards their rehabilitation into the community.[122] Inspectors expressed the hope that early changes along these lines would encourage Boards to make greater use of the home.

96 The description of the home in the SWAG inspection report suggests that it provided a caring and ordered regime focused on meeting the practical needs of children who were in need of long-term care. The emphasis from the mid-1970s on enabling children as far as possible to remain within their families and using residential care as a short-term measure meant that the type of long-term care provided by Manor House was increasingly seen as less appropriate and therefore less necessary. The Management Committee and the staff got little opportunity to find out if they had the will and ability to adapt to these changing circumstances as the impact of the falling numbers on the home's finances became increasingly pressing.

97 By 1982, the number of children in the home had reduced to thirteen and the treasurer reported to the Management Committee on 20 September 1982 that the Bank had been in touch because the home's current account was overdrawn. The Management Committee agreed to accept the Bank's offer of overdraft facilities and to withdraw savings in order to pay accounts.[123] Mr Johnston told the Hughes Inquiry that in the years before the home was closed the low number of children in the home and the related loss of per capita fees meant that the home was running at an annual loss of £30,000.[124] This situation led the Management Committee to conclude that, in view of the reduction in the number of children requiring long-term residential care, the home was no longer financially viable and it arranged for the home to close in November 1984.[125]

98 We will now consider the evidence we received about physical abuse, sexual abuse, emotional abuse, neglect and unacceptable practices in Manor House.

Physical Abuse

99 Three of the witnesses we heard from said they were physically abused in the home. HIA 341 was placed in the home as a baby in 1941 and

122 MNH 10222.
123 MNH 10004.
124 MNH 10144.
125 MNH 10068.

remained there until he was ten years old. He told us he was frequently assaulted by staff and he attributed the hearing loss he suffers from to the smacks he received from staff.[126] He said he was caned by staff and hit with a whip with long strings attached and was told by staff, "Don't cry and don't tell, you cry, you get more."[127]

100 The ICM said in its response to HIA 341's evidence that they found it impossible to reconcile his account to the Inquiry of his time in Manor House with earlier accounts he has given to newspapers in Australia in which he stated that he had no memory of his life prior to being migrated to Australia. HIA 341 explained when he gave evidence in person to the Inquiry that he had not talked about his experiences in Manor House before because he did not want to jeopardise a possible reunion with his mother.[128]

101 HIA 346 was also a resident in the home in the 1940s. He was admitted to the home in 1946 when he was four years old and remained there until he was eight years old. HIA 346 told us he was beaten by staff, and he said in his written statement that he was put in a cold bath after being beaten which he thought was an attempt to stop bruising.[129] When he gave evidence in person he said that he was only guessing that the use of the cold bath was to reduce bruising and that it may have been part of the punishment.[130]

102 The ICM accepted in its statement to the Inquiry that corporal punishment was used in the home in the 1940s, but pointed out that corporal punishment was permitted in children's homes at that time. It stated that the Management Committee took seriously any complaints or allegations about abuse received from the children in the home and gave examples of such responses by the Committee in 1946 and 1947, two of the years in which HIA 341 and HIA 346 were in the home.

103 The first example, from 1946, was of the Management Committee investigating a complaint that two boys had been excessively punished by an assistant matron. As well as interviewing the assistant matron the Management Committee arranged for the boys to be examined by a doctor.

126 MNH 022.
127 MNH 023.
128 Day 45, p.29.
129 MNH 014.
130 Day 45, p.43.

104 The second example from 1947 was of the matron MH 1 reporting to the Management Committee that she had to administer corporal punishment to one boy and some other boys questioned her about it. The Management Committee met with the boys to discuss the matter.[131]

105 The ICM also provided the example of the Management Committee being informed in September 1962 that the behaviour of a member of staff who had been a former resident in the home had been found to be unsatisfactory because it had come to light that when she was a resident she had hit two children in the home. The member of staff in question resigned on the day of the Committee meeting.[132]

106 HIA 365 and his twin brother HIA 290 were admitted to Manor House in February 1964 when they were aged 9 years and remained there until January 1968. They then spent a year living with their father before returning to Manor House for a brief stay from January 1969 to June 1969. HIA 365 said he saw the strap being used on other children, but he was never strapped because he had chronic asthma as a child and was often unwell. HIA 290 told us he did not complain about sexual abuse by a visitor to the home because he was scared he would get strapped or slapped.

107 In contrast HIA 289 was in the home between June 1965 and March 1968, the same time as HIA 365 and HIA 290. He told us that the home was regimented but not harsh. He remembered the matron, MH 3, as firm but fair.[133] He recalled children who misbehaved having privileges taken away or being sent to bed early.[134] He said that if the misbehaviour was particularly serious the child would be taken to MH 3, and she would decide whether the behaviour merited the child being hit on the hand with a ruler. He commented, "I don't remember any of the children being terrified of her".[135]

108 HIA 366 was admitted to the home on 8 December 1972 aged nine years and was discharged just over a year later on 12 December 1973 aged ten years. She told us she was frequently physically abused by the matron, MH 9,[136] and she recounted a particular incident when MH 9 treated her

131 MNH 12001.
132 MNH 161.
133 MNH 085.
134 MNH 088.
135 MNH 088.
136 MNH 078.

roughly because a celebrity who was visiting the home was paying her attention. HIA 366 also said that she was bullied by older children in the home and that she felt they behaved in that way because they were bullied by MH 9.

109 The ICM pointed out that HIA 366 has given a range of dates and lengths of time for her stay in the home in the accounts she had given to the media. HIA 366 accepted when giving evidence in person that she had been confused about the dates of her stay in the home. However, it is the case that MH 9 was the matron when HIA 366 was resident in the home.[137]

110 The ICM told us that there are no records of complaint from children or others about MH 9, nor any record of her being subject to disciplinary proceedings. They gave examples of positive references about MH 9's relationships with children in reports from social workers, and referred to the observation of SWAG inspectors that she was quite protective of the children.[138]

111 HIA 366 also told us that MH 19, who was the Rector of the nearby Christ Church, inspected the appearance of the children before they went across to the Sunday service, and that on one occasion he "clipped" her around the ear because she was wearing the wrong colour of socks for attending church. She said she saw MH 19 hit a male resident (MH 12) in a similar manner because he was wearing the wrong trousers.[139] Rev Coulter, who attended Christ Church as a child and was in his teens when MH 19 came as Rector to the church, spoke on behalf of MH 19, who is now deceased. He said MH 19 was a serious man and he could understand how he could have appeared austere to a child but that he could not imagine him "clipping" a child on the ear.[140]

112 MH 26, the mother of four children in the home, MH 23, MH 24, MH 25 and MH 27, complained to the SHSSB in December 1978 that her children were being "victimised" in Manor House, and that a child had tried to drown MH 25 in the bath.[141] Her complaint was referred to MH 9 who investigated it and reported back to the SHSSB that when she talked in an informal manner to the children involved in the incident MH

137 MNH 078.
138 MNH 134.
139 Day 175, p.18.
140 Day 175, p.64.
141 MNH 343.

25 talked about the fun they had "ducking" each other during bath time. MH 26 was satisfied with this explanation.

113 In August 1980, MH 26 complained that her son MH 23 had been hit with a stick by a member of staff, MH 28, which had left marks on his legs. She also complained that MH 23 had told her that staff pulled his hair and that both her sons MH 23 and MH 24 told her they were beaten if they refused to eat food they did not like. MH 26 stated that the boys had pleaded with her not to report these matters as they were scared that "staff would retaliate on them when MH 9 would be away from the home."[142]

114 MH 73, Assistant Principal Social Worker, investigated this complaint and found that MH 28 had hit MH 23 with one of the sticks he and other boys had brought in from outside and were "skinning" i.e. peeling off the bark, in the kitchen of the home. MH 73 spoke to MH 9, MH 28 and MH 23's brother MH 24, who observed the incident. MH 24 told MH 73 that MH 23 and he had been "cheeky" to MH 28 and unwilling to tidy up the mess they had created in the kitchen, and when MH 23 then rang the fire bell MH 28 had hit him twice with one of the sticks the boys had brought into the kitchen. MH 73 arranged to have MH 23 medically examined and the doctor found a faint bruise on his thigh.[143]

115 MH 73 recorded in the note of his investigation:

> "After some further discussion regarding disciplinary procedures within the Home, I satisfied myself that a stick is not the usual form of disciplining and that any severe disciplining which has to be undertaken has to be done by [MH 9] with a member of staff present".[144]

He also recorded that MH 9 and he had agreed this was an isolated incident that did not merit dismissal, but that MH 9 "would certainly be informing her management committee".[145] We have no evidence of whether this referral was made but when giving evidence to the Hughes Inquiry MH 73 said there were occasions that MH 9 would mention staff performance to the Management Committee.[146] MH 73 met MH 26 and reassured her that it had been emphasised to staff in Manor House that MH 9 was responsible for disciplining children. There is no record of a

142 MNH 350.
143 MNH 346.
144 MNH 346.
145 MNH 347.
146 MNH 10145.

response to the complaints that MH 23's hair was pulled by staff, or that the brothers were being forced to eat food. However, MH 73 concluded in his report of his investigation that he was quite satisfied that "the children are in the best possible place for care at this moment in time".[147]

116 This informal approach to a member of staff striking a child with a stick suggests a lack of formal disciplinary processes. We are of the view that by 1980 such processes should have been in place in the home and should have been used to deal with this incident. We are also of the view that as an **Assistant Principal Social Worker, MH 73 should have expected the use of formal disciplinary processes in a home in which the SHSSB was placing children. We consider that this informal means of dealing with a member of staff who hit a child with a stick amounts to systemic failing by Manor House to ensure the home provided proper care.**

117 During the SWAG inspection of the home in 1981, MH 9 told inspectors that a reprimand or withdrawal of privileges was the usual means of punishment and that children had to contribute to the cost of putting right any damage to property.[148] From their observations of the interactions between staff and children the inspectors concluded that:

> "The staff influence is such in the best sense that organisational controls are seldom required."[149]

However, they noted that a recorded corporal punishment was the application of "three smacks with an open hand on [the] 'tail end'" and reminded the home of the requirement to strictly observe the stipulations about the administration of corporal punishment laid down in the Voluntary Home Regulations.

118 We consider that a warm, firm, but not harsh regime operated in the home and that it was underpinned by an established culture in which the children were clear about how they were expected to behave and about the authority of staff. It is evident that, particularly in the early days, misbehaviour would not have been tolerated. Corporal punishment was permissible, and it was used but it is clear that complaints about excessive punishment were taken seriously and investigated by the Management Committee. We heard evidence about physical punishment which was excessive and

147 MNH 348.
148 MNH 10027.
149 MNH 10210.

not administered in accordance with the statutory regulations governing the use of corporal punishment in children's homes. However, given the level of evidence and the particular, rather than general, nature of the allegations we do not consider that there was systemic physical abuse of children in Manor House.

Sexual Abuse

119 HIA 366 told us that MH 9 took her to her bedroom and sexually abused her and made her masturbate her. This is the only allegation we have received about sexual abuse by MH 9 or any other member of Manor House staff. We do not consider that there is evidence of systemic sexual abuse of children by staff in Manor House.

120 Four of the six witnesses we heard from told us they were sexually abused in Manor House by adult visitors to the home. We also learnt through police material of another resident being sexually abused by a visitor to the home and of a resident being abused outside the home by a man who then came to the home to see him.

121 HIA 341 who was in the home in the 1940s told us that a minister, whose name he could not remember, dressed him in girl's clothing and sat him on his knee. He said that although there was no skin to skin contact he could feel the minister's erection through the silk fabric of the clothing.[150] HIA 341 said he was brought to see the minister by an older boy, MH 2 and that the abuse would happen quite often. When HIA 341 gave evidence in person he said that he also felt through the clothing what he thought was the Minister's finger in his anus.[151]

122 The ICM pointed out that this was the first time that HIA 341 had made claims of this sort about his time in Manor House and that he did not name the minister he said had assaulted him. HIA 341 explained that it was only as an adult that he recalled these events. There is no record of HIA 341 complaining to staff at the time, and we would accept that staff would have regarded a minister as a trustworthy and safe person to have access to children. Therefore, we do not find any systemic failing by the staff of Manor House in relation to this allegation.

150 MNH 023.
151 Day 45, p.10.

123 HIA 365 and HIA 290 are twin brothers, who were in the home in the 1960s. They told us that they were sexually abused in the home by a male visitor who came from the local Army barracks. They gave similar descriptions of the man and described him grooming and sexually abusing them. HIA 365 described how the visitor would sit him on his knee in a darkened television room, put his coat around him and then take his hand and make him masturbate him. He said the man would also abuse him in an upstairs bedroom and would use sweets and gifts such as a mouth organ as bribes. He said that he saw his brother HIA 290 sitting on the man's knee and that he believed other children in the home may have been abused in the same way.[152]

124 HIA 290 described a man sexually abusing him in a similar manner and he remembered the man wearing a trench coat in the television room to hide what he was doing.[153] He recalled the man bribing him with sweets and the promise of a pen knife and telling him not to tell anyone about what he was doing or he would not visit again. He also said that he was aware of other children in the home being abused in a similar manner by the man.

125 It is clear from the accounts given by HIA 365 and HIA 290 that this man effectively manipulated them to ensure their silence and compliance. HIA 290 explained that, although he felt he could talk to the staff at the home about problems, he had been brought up by his father, whose attitude was that children should be seen and not heard, so he did not feel able to report the man's behaviour to staff.[154]

126 HIA 289 was in the home at the same time as HIA 365 and HIA 290 and also described a man abusing him in a similar manner. He said he thought the children called the man "Uncle Bob".[155] He also referred in his statement to an "Uncle Tom" visiting but said that he did not abuse him and he was not aware of rumours amongst the children about him.[156] As HIA 289 was unable to give evidence in person the identity of the man that abused him could not be pursued further with him.

127 HIA 289 described the man fondling him and making him masturbate him in a darkened television room. He described trying to pull his hand away but the man being insistent and using his hand to keep HIA 289's hand

152 MNH 008.
153 Day 174, p.27.
154 Day 174, p.30.
155 MNH 086.
156 MNH 087.

on his penis. HIA 289 said he saw other boys being abused in the same way and described the children's awareness of the abuse:

> "The other children knew what was happening. They would just stare ahead at the television. All the children would dread this man calling their name and asking them to come out and sit on his knee. They would even push and shove each other on the bench so that they would be towards the end of it and he might not pick them. Sometimes, if you had been on his knee, the other children would ask if he had touched you. You might have answered 'yes' or 'no' but no-one would say much more than that. It was never talked about generally. He never bothered with the girls."[157]

128 HIA 289 described the same man playing football and chases with boys from the home in the field at the back of the house, and using the physical contact in such games to fondle their genitals and rub his unshaven face across their cheeks.

129 HIA 365 said in his statement that he believed staff knew about the abuse and indicated they were friendly with the man. At the hearing he described staff sitting in the television room while the man abused children. HIA 290 said that although staff may have been in the television room they would not have necessarily known what was happening as the man always put the light off in the room. HIA 289 said he remembered one child informing the staff of this man's behaviour but he thought the child was just told they were wicked for "making up such stories".[158]

130 In its written statement the ICM explained that no "Uncle" system operated in the home, and that the only record it could find of a soldier visiting the home was a reference in the minutes of the Management Committee meeting held on 20 March 1967 to visits from MH 49, who had been a resident in the home in 1953. The minute recorded that MH 49 was based in Singapore, had been in correspondence with the home since 1962, and that "[MH 49] had visited the Manor House when in Ireland on leave".[159] This reference to MH 49's communications with, and visits to, the home was recorded in 1967 at which time HIA 365, HIA 290 and HIA 289 were resident in the home.

157 MNH 087.
158 MNH 087.
159 MNH 087.

131 The ICM found no other references to MH 49 in minutes or other documentation. Reverend Coulter confirmed when he gave evidence in person that the ICM did not have documentation in relation to MH 49's time as a resident in the home.

132 Coincidently MH 49 contacted the headquarters of the ICM after the public hearings in relation to Manor House had finished. The ICM directed MH 49 to the Inquiry and he co-operated with our investigations and provided a statement about his very limited contact as an adult with Manor House. We were satisfied on the basis of the detailed statement provided by MH 49 that he was not the person who abused children in Manor House.

133 The ICM explained in its written statement that there was controlled access to the home, children were not allowed to answer the door and any visitors had to be approved by the matron or a member of the Management Committee. It also explained that the policy of supervision within the home was that staff should be seen around and be with the children as duties permitted and that whilst these arrangements were enough to regularly safeguard children most of the time, they were:

> "...unfortunately not enough to prevent an opportunistic, determined and devious abuser in this case."[160]

134 ICM also stated that if a member of staff had responded to a report from a child about this man's behaviour in the way recalled by HIA 289, that would have been totally contrary to the expectations and actions of the Management Committee in relation to the management of sexual abuse at that time.[161]

135 We accept ICM's account of the efforts the Management Committee and staff made to keep children safe. We noted a number of references in the minutes of Management Committee meetings to requests for visits to the home and proposed outings being refused because the members did not think they would be appropriate for the children. Also, as commented on in the SWAG inspection report as late as 1981, parents visiting their children were confined to meeting them in the front hall of the home.

136 We recognise that watching television in a darkened room would have been common practice in the late 1960s and we would not expect staff to have seen such behaviour as suspicious. However, we consider that the

160 MNH 053.
161 MNH 095.

behaviour of the man in question in the television room as described by the witnesses should have raised questions about why he had nine-year-old boys on his lap, and the discomfort amongst the children described by HIA 289 should have been noticed. Also the special interest he took in some boys, such as buying HIA 365 a mouth organ and being upstairs with him, should have raised some suspicions. We noted that in 1966 the Management Committee dealt with a case of peer sexual abuse and instructed MH 3 "to keep a strict watch" on the boy, to which MH 3 responded that it was already being done.[162] So the matron and some of the staff were aware of the potential of sexual abuse of children at the time HIA 365, HIA 290 and HIA 289 were being abused in the home. Given that context we consider the behaviour of the man and the children's reactions to him should have been noticed. **Therefore, in relation to these cases of sexual abuse we consider that there was a systemic failing on the part of the staff of the home to take proper steps to prevent, detect and disclose abuse**.

137 We received files from the police about the investigation of another case of alleged sexual abuse of a child resident in Manor House in the 1970s. In 2000 police investigated allegations of abuse at Macedon children's home and identified MH 20 as an alleged abuser. Police found that MH 20[163] had been a serving soldier and had become a voluntary helper at Manor House prior to his discharge from the regular Army. He subsequently volunteered with Barnardo's.

138 The police carried out further inquiries to try to identify other children who might have been abused by this man and interviewed MH 41, whose sister had been fostered by MH 20 and his wife. MH 41 told police that he had been sexually abused by MH 20 at Manor House over a period of five or six years. He told police that the abuse, which included masturbation and oral sex, took place in a bedroom, greenhouse and football pitch in the home and also happened when he spent weekends at MH 20's home. He said the abuse started when he was 10 years of age, and when he was approximately 14 years of age MH 20 involved his wife MH 21 in the abuse and that all three of them engaged in sexual intercourse together. MH 41 explained that the frequency of the abuse reduced when he reached his mid-teens and began to see less of MH 20 and MH 21. He said he never felt able to tell anyone about the abuse.[164]

162 MNH 104.
163 MH 20 is referred to as BAR 4 in the chapter dealing with Barnardo's homes.
164 MNH 6379–6381.

139 MH 20 was interviewed by police on 12 December 2002.[165] He told them that he came to Northern Ireland in 1969 as a soldier and in 1977 he joined the UDR. He explained that his first contact with Manor House was when his Army regiment organised trips for the children and gave them gifts.[166] When he was living in Northern Ireland after being medically discharged from the Army he went back to visit Manor House, spent time with the children in the home, and took them on day trips and to his home.[167] MH 20 admitted he had feelings for MH 41 and that they had sexual relations in Manor House and at his home. He said that he had not forced MH 41 to do anything against his will, and indicated that he did not accept all that MH 41 alleged happened.[168]

140 MH 21 was interviewed and said she remembered MH 41 being in her home and, although she was not certain, there was a possibility she had sex with him since she did have sex with adolescents because her husband wanted her to do so.[169]

141 On 22 December 2004 the DPP directed no prosecution of MH 20 and MH 21 because there was no reasonable prospect of a conviction based on the available evidence.[170]

142 It is clear that MH 20 was viewed by staff at Manor House as a person who could be trusted, and that he was therefore allowed considerable access to the children, including taking them out on trips and taking children to his home. The HSCB provided extracts from social work records which show that during a visit to Manor House, MH 41's social worker, who was employed by the EHSSB, learnt about plans for him to stay with MH 20 and MH 21 from 27-30 December 1975 with another boy from the home.[171] The social worker recorded:

> "MH 9 confirmed this and was reassuring about the couple's interest in the children as they have been regular visitors over a number of years."

143 The HSCB commented that this extract shows that MH 9 made arrangements for a child to spend a weekend out with a family without securing prior consent from the child's social worker. However, it also

165 MNH 6401.
166 MNH 6408.
167 MNH 6408.
168 MNH 6419–MNH 6420.
169 MNH 6502.
170 MNH 6334.
171 MNH 15016.

accepted that it shows that the social worker took MH 9's personal view of the couple to be sufficient information as to their suitability.[172] The HSCB pointed out that the social worker's response was not in keeping with the approach Mr Bunting told the Inquiry he took in July 1972 when he informed voluntary children's homes and EHSSB staff that couples who wished to befriend children resident in voluntary homes had to be approved by the Welfare Department prior to the children going out with them, even for a day.[173]

144 The HSCB also pointed out that subsequent to MH 41 being allowed to stay with MH 20 and MH 21 the couple successfully completed a rigorous assessment process to become foster parents, and that there was clearly no identification of any "mal intent" towards children on their part at that time. They submitted that it was likely, therefore, that any assessment of the couple's suitability to befriend MH 41 would, in all likelihood, have resulted in approval of the arrangements.[174]

145 From MH 41's account, MH 20 clearly groomed him and secured his compliance in sexual activity. It may have been that more questioning of MH 41 about the time he spent with MH 20, particularly at the start of the sexual abuse, might have identified what was happening. However, it is clear that MH 20 acted in a covert and manipulative manner, and, as the HSCB pointed out, suspicions were not raised about him during an extensive assessment process to be approved as a foster parent. Therefore, we do not consider that staff in Manor House should be criticised for not identifying the risk that a plausible man, who was introduced to them through the Army and was a member of the UDR, could present to children.

146 Another known incident of sexual abuse related to the indecent assault of a child MH 23 who was resident in Manor House. This assault was committed in May 1982 by David Jarvis. At that time Mr Jarvis was on bail in relation to a similar assault against a male child who was resident in Barnardo's, which he was subsequently convicted of in December 1982.

147 MH 23 was at a camp with the Boys Christian Missionary Society in Portrush in the summer of 1981. During that holiday he attended a stock car race and met Mr Jarvis who allowed him to use his camera. About a year later MH 23 was leaving a youth club in Lisburn and met Mr Jarvis

172 MNH 15017.
173 RUB 5569.
174 MNH 15020.

again. He agreed to go to Mr Jarvis's house, where Mr Jarvis sexually abused him. Around a month after this, on 18 June 1982, Mr Jarvis came to the outside of Manor House and tried to persuade MH 23 to go to his home, and he said he would pay him for sexual favours. MH 23 refused to go with him and went back into the home.

148 Mr Jarvis left but returned a short time later and MH 23 became upset and told members of staff that he did not want to see Mr Jarvis. A member of staff MH 34 told a colleague to take down a description of Mr Jarvis's car and its registration number and then went out and told him to leave, which he did. MH 23 then told staff about his previous encounters with Mr Jarvis.[175] The police were subsequently contacted and MH 23 and the relevant members of staff were interviewed. Mr Jarvis was identified by the police and convicted on 18 March 1983 of indecent assault of MH 23. We consider that the staff in Manor House acted promptly to protect MH 23, and that MH 34's quick thinking was commendable and assisted the police in apprehending Mr Jarvis.

149 On 4 February 1985 Mrs Brown of the Child Care Branch of the DHSS wrote to Chief Superintendent Pollock of the RUC to express concern that although staff in Manor House and Barnardo's had each co-operated with relevant police investigations they had not been informed about the outcomes of the investigations and the subsequent convictions. Mrs Brown explained that the Department was anxious to ensure that in future any home involved in this way would be informed about the outcome of police investigations.[176] On 5 April 1985 the RUC confirmed that arrangements had been put in place to ensure that would happen.[177] We consider it appropriate and helpful that the DHSS followed up this matter in this way.

Peer Sexual Abuse

150 Although only one witness told us about being abused by a peer in Manor House we learnt from police material that peer sexual abuse was a significant problem in the home in the 1970 and 1980s. The witness who told us about peer sexual abuse was HIA 289 who was in the home from 1965 to 1968. He told us that he was sexually abused by an older resident called MH 18, who would go into a rage if HIA 289 resisted him administering oral sex.[178]

175 MNH 6277/8.
176 MNH 6239-6240.
177 MNH 6230.
178 MNH 087.

151 HIA 289 said this sexual abuse happened in the fields behind the home and that although he remembered staff supervising the playground they did not supervise all periods of play time.[179] The ICM told us that they had no record of complaints about MH 18's behaviour, and that if HIA 289 had reported the abuse it would have been dealt with promptly. They provided documentation to support this view, which detailed how the Management Committee dealt with a case of peer sexual abuse that was referred to them in 1966, which was during the time that HIA 289 was resident in the home.[180]

152 Peer sexual abuse in the home between 1975 and 1980 came to the attention of the police in June 1985, the year after the home closed.[181] On Thursday 20 June 1985, a former resident of Manor House, MH 31, then aged 17, broke into the home of another former resident MH 12 and assaulted him with a poker. MH 12 overpowered MH 31, who then went on to spend the night in MH 12's home. MH 12 was concerned about MH 31 and the next morning, Friday 21 June 1985, he asked his own social worker Helen Taylor to visit to speak to MH 31. Helen Taylor visited and after speaking to MH 31 about what was concerning him brought him to see his own social worker Alan Morrison. [182]

153 MH 31 told Mr Morrison that MH 12 had sexually abused him in Manor House and that he had broken into MH 12's home on two occasions and attacked him on the second of these occasions because he was so distressed about the abuse. He further said that on the previous night when he had stayed in MH 12's home they had shared a single bed and MH 12 had sexually molested him twice during the night.[183] Alan Morrison agreed with MH 31 that they would go to the police on the following Monday, 24 June 1985, so that MH 31 could admit to the burglaries and assault and explain why he had committed the offences.

154 On Saturday 22 June 1985, MH12 visited his grandmother and told her and his brother who was also visiting about MH 31 breaking into his house and attacking him. He told them that he did not want to involve the police. As MH 12 was leaving his grandmother's house he collapsed and was admitted to hospital where he remained in a critical condition for a

179 MNH 087.
180 MNH 095.
181 MNH 6001-6182.
182 MNH 6027-6028.
183 MNH 6028.

number of days. His father was told about the burglary and the attack and he reported them to the police.

155 MH 31 was interviewed by the police on Sunday 23 June 1985; he admitted the crimes but explained that they were acts of revenge because MH 12 had repeatedly sexually assaulted him when they were both residents in Manor House between 1975 and 1980. The police subsequently interviewed MH 12 who admitted to sexual activity with MH 31 when they were in Manor House and on two occasions in his flat. He also explained that when he was a child in Manor House, just before he started primary school, older boys initiated sexual activity with him and although he did not want to take part they persisted and he did what they wanted.[184] He named other male residents of Manor House that he had sexual relations with during the eleven years he spent in the home.[185] He explained that he moved from Manor House to Kincora, and it was when he was abused in that hostel by a member of staff, William McGrath, that he began to realise his behaviour in Manor House was wrong. As a result of the statements of both men, and the possibility that the allegations might impinge on the Kincora Inquiry, the police decided to undertake a full investigation.[186]

156 The police traced and interviewed five other males who were former residents of Manor House during the period 1975 to 1980, MH 33, MH 24, MH 23, MH 39 and MH 32. Allegations were made about another former resident MH 30 but the police were not able to trace him.

157 From these interviews the police determined that the claims of sexual misbehaviour at the home between residents were substantiated, that the sexual activity had initially taken the form of experimentation but on some occasions progressed as far as buggery. During the interviews the former residents described consensual behaviour but also in some instances coercive behaviour. They all confirmed that they had not told staff in the home about the sexual activity. The police concluded from their interviews:

> "There is evidence to suggest that it began at a very early age, perhaps as young as 5 years and new boys would be introduced to sexual acts almost upon their arrival at the Home."[187]

184 MHN 6081.
185 MHN 6081.
186 MNH 6031-6043.
187 MNH 6010.

158 This conclusion is supported by disclosures MH 23 made to social workers on 31 July 1985 about his time in Manor House. MH 23 described older male residents in Manor House threatening him to make him engage in sexual activity and explained that he had not told anyone about it because he was afraid of being beaten up.[188] MH 23 was admitted to Manor House when he was approximately four years old and he disclosed that the peer abuse commenced when he was five to six years old.[189]

159 The police decided that four of the five former residents they interviewed would be weak and/or uncooperative witnesses. However, given the admissions by MH 12 and MH 33 and the evidence given against them, particularly that of MH 31, the police decided to arrest them on suspicion of committing an indecent assault on MH 31 by virtue of Section 2 of the Criminal Law Act (Northern Ireland) 1967.[190]

160 The matter was referred to the DPP who directed that no-one should be prosecuted in respect of what had happened in Manor House or in respect of the aggravated burglary, due to the lapse of time, the interconnection between the aggravated burglary and the allegations of abuse and the reluctance of anyone involved to pursue the allegations.[191]

161 In February 2013, MH 31 contacted police to report the abuse he suffered in Manor House from 1975 to 1980. Police tried unsuccessfully to speak to him and then discovered in June 2013 that he, sadly, had taken his own life in March of that year.[192]

162 It is clear from the police investigations that during the period 1975 to 1980 there was sustained peer abuse in Manor House and from 1975 to 1977 there were at least eight boys involved in this abuse. While the three main instigators were in their teens, one of the boys they abused was six years old and another was seven years old. The activity is described as regular and the evidence suggests that on at least one occasion four boys engaged in oral sex together. This indicated to us that the level of supervision of the children particularly at night time was inadequate. **Given this level of activity and the fact that at that time it involved at least over a third of the children resident in the home we consider that there was a systemic failure by the staff to take all proper steps to prevent, detect and disclose peer sexual abuse in the home**.

188 MHN 375.
189 MNH 375.
190 MNH 6022.
191 MNH 6020.
192 MNH 6183.

163 Another case of peer sexual abuse came to the attention of staff in Manor House on 14 September 1982[193] when a child in the home MH 38 told a member of staff MH 28 about behaviour between her brother MH 39 and another resident MH 25 which was sexual in nature. She said she saw the children in a room with their underwear down and heard MH 25 say "stop it [MH 39] its sore".[194] This conversation happened on a Saturday morning. In the absence of the matron MH 9 who was on holiday, MH 28 and her colleagues decided to do nothing further until they could contact MH 39's social worker on the following Monday.

164 MH 39's social worker, MH 57, was informed on Monday morning and came to see MH 39 in the home that morning, but he refused to stay in the meeting with her even before she could raise the matter with him. MH 28 interviewed MH 25 on Monday afternoon, who told her that the incident as described by MH 38 had happened, and that MH 39 had forced her to be involved, she had told him to stop, and had tried to push him off. She said that MH 39 had made a previous attempt to have intercourse with her about a year before, and had behaved in a similar way with another female resident. We have seen no evidence that the allegation that MH 39 behaved in a similar manner with another girl in the home was investigated further by Manor House or that her social worker and/or the police were informed about it. We consider that this **allegation should have been investigated further and that the failure to do so was a systemic failing by Manor House staff to take all proper steps to prevent, detect and disclose abuse**.

165 MH 28 left a telephone message for MH 25's social worker asking her to contact her and when she had not heard back from her by 9.45pm that evening she contacted the social worker's senior, Mr Forbes. Dr McCann, the Chairman of the Management Committee, and Mr Johnston, the Honorary Secretary were also told on the Monday evening about the incident. Dr McCann expressed his concern to staff that MH 25 had not been medically examined. MH 39 was interviewed by his social worker the next day and admitted to the behaviour and was subsequently interviewed by police. MH 25 was also interviewed by police and medically examined by a police doctor who found that her hymen was stretched but still intact. Mr Forbes pressed for MH 39 to be removed from the home and said that if that did not happen he would remove MH 25 and her sister MH 27 from

193 MNH 390–394.
194 MNH 390.

the home. It was agreed that MH 39 would be removed but only after he had completed a planned interview and tests for admission to the Army that were taking place on the Thursday of that week. MH 28 recorded that MH 57, MH 39's social worker, felt that the Army should not be told about the incident until such times when it would be necessary, and that "We assured MH 39 about this and he seemed happier."[195]

166 We have received no information about the nature of the police investigations or its conclusions, but when MH 39 was interviewed by police in 1985 about allegations of peer sexual abuse in Manor House[196] there was no reference in the record of that interview to any previous police action in relation to his time in the home. We therefore conclude that no formal action was taken beyond the police interviewing MH 39 and his removal from the home.

167 Mr Forbes' manager, MH 73, Assistant Principal Social Worker, SHSSB, recorded his concerns about how Manor House staff had handled the matter and put on record that on MH 9's return from holiday he intended to raise with her why there was a delay in informing his department about the matter, why MH 39's social worker was informed before MH 25's and "the attitude that the boy would appear to have been the injured party and that we might be spoiling his chance to gain admission to the Army."[197] We have seen no documentation about whether these matters were raised with MH 9 and if so what her response was.

168 The SHSSB informed the DHSS about matters relating to MH 26's family because of the potential of MH 26 going public with her complaints about the care her children were receiving. Chris Walker of the DHSS visited the home on 22 September 1982 and met with MH 9 who gave him a summary of the events in relation to MH 39 and MH 25 and how they were managed. Mr Walker produced a note of this meeting[198] but there is no record of any further involvement by the DHSS.

169 When MH 28 spoke to MH 25 about the incident with MH 39 she asked if he had behaved in a similar way with MH 25's sister, MH 27. MH 25 said he had not but that his brother MH 72 had behaved in a similar manner with MH 27 two years previously. We have received no evidence to suggest that this allegation was investigated further by Manor House staff at that time.

195 MNH 10122.
196 MNH 6043.
197 MNH 396.
198 MNH 2551-2552.

170 However, three years later, when MH 27 was in another children's home she told staff she had been raped in Manor House. At that time she was referred to a child psychiatrist who concluded from the detail MH 27 provided that a sexual incident with MH 72 had occurred[199] and "action was taken at the time".[200] If the psychiatrist was correct that action was taken at the time the incident occurred, this may explain why Manor House staff did not record any reaction to MH 25's disclosure about MH 27 and MH 72 as the information was not new to them.

171 The SHSSB referred another alleged incident of peer sexual activity in Manor House to the police in August 1985 following MH 23's disclosure to social workers that while he was resident in Manor House he had sexual intercourse with his sister MH 25 who was also a resident in the home.[201] MH 23 told the social workers that he had sex with MH 25 "lots of times" in different places in Manor House including his bedroom, behind the house and in the yard. He said that a member of staff MH 34 had caught them acting in this way. He also said that he had sexual intercourse once with a female resident in Manor House MH 36 and more than once with another female resident, MH 38. The social workers also interviewed MH 25 and she confirmed that she had engaged in sexual activity with MH 23 in Manor House but stated that it only happened twice and that staff had only caught them on the first occasion.

172 In her record of the interview with MH 25, the social worker Miss Logan recorded reminding MH 25 of an incident in 1982 when staff at Manor House found MH 23 and her together in his room and their admission to "tickling each other". MH 25 agreed that had happened but stated that they had not had sex on that occasion.[202] The awareness of Manor House staff about the sexual contact between MH 25 and her brother MH 23 was also confirmed when Mr Walker met with MH 9 to discuss the incident between MH 39 and MH 25. At that meeting MH 9 told Mr Walker that MH 25 had been involved in incidents of sexual exploration with her older brother MH 23 and had been warned of the dangers involved, and told how to avoid such incidents in the future. There is no evidence to indicate if extra monitoring and supervision of the siblings were put in place to try to prevent a repeat of this behaviour.

199 MNH 360.
200 MNH 363.
201 MNH 6567.
202 MNH 379.

173 Police interviewed MH 25 in October 1985. She confirmed that her brother MH 23 had sex with her when they were both resident in Manor House. However, police reached the view through questioning her that she was describing sexual touching rather than intercourse. MH 23 was also interviewed by the police and although he said he had sex once with MH 25 in Manor House, the police reached the view from his description of what had occurred that the activity amounted to touching of genitalia rather than full sexual intercourse.

174 The accounts the young people gave to police were inconsistent with the ones they gave to social workers in which they each said more than just touching took place in a bedroom of Manor House. However, on the basis of what the children told them, the police concluded that what occurred amounted to sexual exploration and the DPP directed no prosecution on 9 January 1986.[203] However, the Detective Inspector who submitted the recommendation of no prosecution expressed the view that there was a case for "somewhat more supervision" of MH 23 and MH 25 to try and prevent a reoccurrence of similar type behaviour. He suggested that this view could be relayed to the Department in a letter when the result of the investigation was being forwarded to them for their information.[204] We have no evidence about whether this happened but we noted the inference that as a matter of routine the Department was informed of the outcome of police investigations of this sort. We consider that the EHSSB responded appropriately to these allegations and promptly referred them to the police for investigation.

175 MH 23 was admitted to Manor House in December 1973 when he was three and a half years old and he stayed there for almost ten years. He told social workers and the police that from an early age in Manor House he was initiated into sexual activity and then went on to initiate such activity with other children. His behaviour as described by him and his sister MH 25 went beyond sexual exploration to attempted sexual intercourse. **We consider the extent to which MH 23 was sexually active from an early age with girls and boys in Manor House indicates a lack of supervision that amounted to a systemic failing by staff to prevent, detect and disclose abuse in the home**.

203 MNH 6553.
204 MNH 6559.

Unacceptable Practices

Treatment of Enuresis

176 As previously referred to, we know from MoHA documentation that in 1953 officials protested to the Chairman of the Management Committee about the home's practice of making children who wet the bed sleep in "an awful little room in the basement".[205] We heard evidence from only one witness about being punished for wetting the bed. HIA 341 described being put in a room where coal was kept which was called the dungeon as a punishment for wetting the bed.[206] HIA 366 also told us that she and her brother were put in a cold, dark, wet cellar in the home as a punishment.[207]

177 HIA 341 said he wet the bed daily and that staff strapped him to his bed and left him lying on wet sheets sometimes for as long as 24 hours and that he was put head first into a cold bath and held down while he was being washed as a punishment for wetting the bed.[208] He said he remembered another boy in the home being treated in a similar manner.[209]

178 HIA 341 also described staff using enemas and a buzzer system to prevent him wetting the bed. We know from the report of the 1981 SWAG inspection of the home that at that time staff woke children at night to go to the toilet to prevent them wetting their beds. Although the SWAG inspectors recommended this practice should cease the Management Committee, guided by the two medical doctors in its membership, justifiably decided that it should continue as the children were generally unaware that they had been taken to the toilet.[210]

179 **It would appear that in the 1940s and 1950s there was a harsh response by staff to children who suffered from enuresis, including the segregation of children who wet their beds and making them sleep in unacceptable conditions. We consider that this unacceptable practice amounted to a systemic failing to ensure the home provided proper care**. However, we also recognise that even at that time attempts were made by staff to prevent bed-wetting occurring rather than just using punishment of it as a deterrent.

205 MNH 2905.
206 MNH 022.
207 Day 175, p.14.
208 Day 45, p.7.
209 MNH 022.
210 MNH 10079.

180 HIA 341 said that an older boy called MH 2 was involved in helping staff to put him in the "dungeon". This is a reference to the same boy that HIA 341 said brought him to a minister who sexually abused him. HIA 341 indicated that the boy might have been an altar boy. ICM pointed out in its response to HIA 341's statement that the Church of Ireland did not have altar boys. When HIA 341 gave evidence in person he clarified that he thought the boy had some kind of clerical connection.[211]

181 HIA 346 who was in the home in the 1940s described being attached by a rope to a brick to stop him running away and being hit by staff for dropping the brick on his toes. He also said he was tied to his bed at night.[212] We consider such practices to be unacceptable.

182 HIA 366 complained about the children from the home being marched to Christ Church each Sunday morning and "being sneaked round the side of the Church" and made to enter the church through a side door rather than the main entrance.[213] She said she tried to complain to MH 19 who was the Rector of Christ Church about being marched to church but that he ignored her.[214]

183 Rev Courtney explained that seating was reserved for the children from the home and that the door they entered through was the one nearest to the reserved seating. He explained that this arrangement was similar to one used in a church in which he was the rector, where seating was reserved for children from a local residential grammar school. We accepted Rev Coulter's explanation and found it satisfactory. He also indicated that he thought that if MH 19 had heard a complaint of a serious nature from a child he would have responded to it.[215]

184 HIA 289 described being made to go to church and Sunday school and how on one occasion, when he tried to resist attending by holding on to railings, his fingers were prised off the railings and he was dragged into church.[216]

185 The ICM explained in its written responses to HIA 366 and HIA 289's statements that the home was set up with the purpose of providing a stable home in a Christian atmosphere for orphans or children from broken homes to help them to develop spiritually, physically and intellectually to

211 Day 45, p.9.
212 MNH 014.
213 MNH 079.
214 Day 175, p.31.
215 Day 175, p.65.
216 MNH 085.

their full potential.[217] Therefore, the children attending the local church and availing of church activities and organisations for children was a normal and regular part of the way the home met its goals[218] and a key component of its care.[219]

186 HIA 366 told us she was put into a bath with a nineteen-year-old boy; she did not indicate that there was a sexual element to this incident.[220] This is the only allegation of this sort that we heard.

187 We carefully considered the accounts of unacceptable practices within the home. With the exception of the treatment of enuresis we did not discern patterns of behaviour by staff that would indicate systemic abuse.

Emotional Abuse

188 HIA 346 told us that staff threatened him that his mother would not visit if he misbehaved,[221] and HIA 341 told us that staff threatened to send him home to his mother if he did not behave, which he said he found confusing and distressing.[222] HIA 366 said that on occasion when her mother visited the home she was not allowed to see her.[223]

189 HIA 366 also said that she and her brother who was admitted to the home at the same time as her were kept separate.[224] When she gave evidence in person she clarified that she saw her brother at meal times but not at play time. ICM explained in its response to HIA 366's evidence that Manor House did not have a policy of separating siblings and that at times they made up the majority proportion of the residents. It also pointed out that in any case the home was small and it would not have been possible to keep siblings separate.[225]

190 We consider that making threats to children about removing access to their parents was very poor practice. However, we did not consider that the evidence we heard about isolated incidents of this nature amounted to systemic abuse.

217 MNH 10023.
218 MNH 093.
219 MNH 136.
220 MNH 078.
221 MNH 014.
222 MNH 021.
223 MNH 078.
224 MNH 078.
225 MNH 135.

Neglect

191 As we have previously indicated we consider the physical conditions in the home in the 1950s amounted to a systemic failing by the ICM General Committee and the Management Committee to ensure the home provided proper care.

192 HIA 366 remembered the canteen of the home being full of cockroaches[226] and the ICM accepted that there was an infestation of cockroaches in September 1970 but that it was in the basement not the canteen and that the Public Health Services were informed and immediate action was taken to eradicate them.[227]

193 HIA 366 explained that she had been diagnosed with Coeliac disease when she was resident in Lissue and that she was given the wrong type of food in Manor House, which made her unwell.[228] The ICM in its response explained that at the time of HIA 366's admission to the home a letter from Antrim Welfare Authority made clear that they had not yet obtained her medical cards and there are no records to show the home subsequently receiving them. The HSCB accepted in its response to HIA 366's statement that there was some involvement of Country Antrim Welfare Committee at the time of her admission to Manor House, but explained that the level of that involvement could not be assessed as a relevant social work file had not been located. However, it pointed out that as HIA 366 was placed in Manor House on a voluntary basis Antrim Welfare Authority would have relied on information about her health being provided by her parents.

194 We asked HIA 366 if she remembered having a medical examination when she entered the home and she said she did not.[229] We consider it poor practice that relevant information about HIA 366's general health was not pursued by the home and that Antrim Welfare Committee did not persist in getting medical cards and birth certificates for HIA 366 and her brother as they indicated to the home they would.[230]

195 HIA 366's complaint about being given inappropriate food was the only complaint that we received about the food provided in Manor House. We

226 MNH 077.
227 MNH 133.
228 MNH 077.
229 Day 175, p.33.
230 MNH 139.

noted the references to a mother saying in 1953 that her children were complaining that the food in the home was dull and inadequate, and a mother complaining in 1980 that her sons were forced to eat food they did not like. However, we also noted the comment from HIA 289 that the food in the home was probably better than he and his brother had eaten before and that if they wanted more food they could have it.[231]

196 Apart from our finding in relation to the conditions for children in the home in the 1950s we do not consider that the evidence we received indicates that there was neglect in the home that amounted to systemic abuse.

197 The early years of the ICM's funding, management and running of Manor House as a children's home were severely hampered by lack of funds and resulted in unacceptable conditions for children resident in the home. This situation was allowed to continue for many years and it indicates that the Management Committee at the time were incapable of ensuring that proper facilities were provided for the children. It is also the case that the Management Committee received only very limited assistance and support from the General Committee of the ICM although that organisation was ultimately responsible for meeting the conditions of the Trust it entered into with Miss Stannus. However, the new Management Committee, which was appointed in June 1953, succeeded in creating and maintaining better conditions greatly assisted by the funding it received from welfare authorities.

198 It is clear from the documentary evidence we have considered that the Management Committee and the staff showed a keen interest in the care and wellbeing of the children and endeavoured to provide a safe and secure home for them. We noted that even in the periods when the physical aspects of care were unsatisfactory the MoHA recorded that the children appeared happy. Also, although inspectors in 1981 found Manor House to be a somewhat out-dated children's home they were positive about the care the children were receiving and the trusting relationships that were apparent between children and staff.

199 In this chapter we have identified areas of poor practice in Manor House and we have also made the following findings in relation to systemic abuse.

231 MNH 085.

Conclusions and Findings

The ICM

200 **We consider the irresponsible approach by the General Committee of the ICM to re-open Manor House as a children's home amounted to a systemic failing to ensure the home provided proper care.**

201 **The general state of dilapidation of Manor House in 1953, the inadequate sleeping, toilet and washing facilities for the children, the poor heating and the low staffing levels amounted to a systemic failing by the Management Committee to ensure the home provided proper care.**

202 **The Management Committee's delay in appointing an officer in charge during the period August 1963 to June 1965 and its failure to appoint a monthly visitor amounted to a systemic failing to meet statutory requirements and ensure the home provided proper care.**

203 **The Management Committee's failure in the early 1970s to engage directly with the MoHA to find out more about and address Miss Forrest's criticisms of the home amounted to a systemic failing on its part to ensure the home provided proper care.**

204 **MH 9's decision with Assistant Principal Social Worker MH 73 in 1980 that an informal approach should be used to deal with a member of staff hitting a child with a stick amounted to a systemic failing to ensure the home provided proper care.**

205 **In relation to the sexual abuse of HIA 365, HIA 290 and HIA 289 by a male visitor to the home there was a systemic failing on the part of the staff to take proper steps to prevent, detect and disclose abuse.**

206 **The extent of sexual activity between boys in the home in the period 1975 to 1977 indicates a lack of supervision of children particularly at night time which amounted to a systemic failure by staff to take all proper steps to prevent, detect and disclose peer sexual abuse in the home.**

207 **The lack of investigation of the claim by MH 25 that MH 39 had sexually interfered with another girl in the home as well as her amounted to a systemic failing by staff to take all proper steps to prevent, detect and disclose abuse.**

208 **The lack of supervision that allowed MH 23 to be sexually active from an early age with girls and boys in Manor House amounted to a systemic failing by staff to prevent, detect and disclose abuse in the home.**

209 **The harsh response by staff in the 1940s and 1950s to children who suffered from enuresis, including segregating these children and making them sleep in unacceptable conditions amounted to a systemic failing to ensure the home provided proper care.**

The MoHA and the DHSS

210 **The lack of inspection of Manor House for a period of over two and a half years following the initial registration of it as a children's home amounted to a systemic failing to ensure the home provided proper care.**

211 **We consider the MoHA's failure to ensure that the Administering Authority met its statutory responsibilities to appoint a person in charge of the home during the period August 1963 to June 1965 and to make arrangements for monthly visiting amounted to a systemic failing to implement statutory requirements and ensure the home provided proper care.**

212 **The low level of formal inspections of the home in the 1960s, and the MoHA's failure to raise Miss Forrest's criticisms of the home in the early 1970s with the Management Committee amounted to a systemic failing by the MoHA to ensure the home was providing proper care.**

213 **We consider the continuing lack of formal inspections up until 1978 was unacceptable, particularly given the history of the home, and amounted to a systemic failing by the DHSS to ensure the home was providing proper care.**

SHSSB

214 **Assistant Principal Social Worker MH 73's agreement with MH 9 in 1980 that an informal approach should be used to deal with a member of staff who hit a child in the care of the SHSSB with a stick amounted to a systemic failing by the SHSSB to ensure the home provided proper care.**

Chapter 21:

Module 12 – Congregation of Our Lady of Charity of the Good Shepherd

Introduction

1 As the Chairman explained on 4 November 2015, and again in his opening remarks at the start of this module on 7 March 2016, in this module the Inquiry investigated only those allegations made to it in relation to institutions in Northern Ireland run by the Roman Catholic female religious order The Congregation of Our Lady of Charity of the Good Shepherd (also known as the Good Shepherd Sisters) by those witnesses who were under the age of eighteen when they were placed in one of these institutions. This was because only children in residential care who were under the age of eighteen are within our Terms of Reference. For convenience in this chapter we refer to the Congregation as the Good Shepherd or the Good Shepherd Sisters.

2 The Inquiry investigated allegations relating to Good Shepherd institutions at three locations in Belfast, Derry and Newry. Because of the small number of applicants to the Inquiry who were in each institution, and because some of them were in more than one of the institutions, we decided to investigate all three in the same module. Module 12 started on Monday 7 March, 2016 and the public hearings extended over seven working days, finishing on Tuesday 15 March, 2016.

3 Although there were a number of references by witnesses to their experiences, or the experiences of others, when working in laundries in the three institutions we have investigated, the Inquiry has not engaged in a wider investigation into what are commonly called Magdalene homes or laundries, or mother and baby homes. Because such institutions contained adults over the age of eighteen, and as our Terms of Reference confine us to examining residential homes or institutions for children under eighteen, the experiences of people in such institutions who were over eighteen are outside our Terms of Reference. Whether their experiences should be investigated is a matter for the Northern Ireland Executive and the Northern Ireland Assembly.

4 During Module 12 we heard from nine applicants, seven in person and two whose written statements were read out because they were unable to attend due to poor health. We also received two statements from individuals who came forward to offer favourable accounts of their time as children when they were looked after by the Good Shepherd Sisters in these three institutions.

5 We heard evidence from five Good Shepherd sisters who served in one or more of the three homes at various times, and from Sr Ethna McDermott on behalf of the Congregation. We received witness statements and substantial quantities of material from the Good Shepherd Sisters, from the HSCB, and a small amount of material from the PSNI. We also received a witness statement from Dr Hilary Harrison on behalf of the Department of Heath Social Services & Public Safety.

The Good Shepherd Sisters

6 The Congregation of Our Lady of Charity of the Good Shepherd was formed in June 2014 by the amalgamation of the Order of Our Lady of Charity and the Order of Our Lady of Charity of the Good Shepherd founded by Sr Mary Euphrasia Pelletier in 1835 in Angers, France. On 27 June 2014, the Congregation of Our Lady of Charity of the Good Shepherd canonically reunified with the Congregation of Our Lady of Charity. The two Congregations shared a common origin namely as the Order of Our Lady of Charity, which was founded in Normandy in France in 1641 by the then Father John Eudes, later St John Eudes. The Order had the stated goal of caring for girls and women. The re-unified Congregation has in excess of 4,000 members working in approximately 75 countries.

7 For the sake of completeness we should explain that within the Good Shepherd Sisters there was (and still is) a separate group of sisters who devote themselves solely to prayer and to the contemplative life (Contemplative Sisters). Although in some instances they resided in separate accommodation neighbouring the Apostolic Sisters' site, as in Belfast, to all intents and purposes the Contemplative Sisters were and are entirely separate from their fellow sisters who were and are engaged in apostolic work with the community (Apostolic Sisters).[1] The Inquiry is solely concerned with the work of the Apostolic Sisters.

8 In 1825, Sr Mary Euphrasia Pelletier was appointed superior of the community of the Order in Tours in France. In 1829 she was asked by the Bishop of Angers to set up a home for girls and women in that town. Sr Mary did that in 1829 and the home was called 'Good Shepherd'.[2]

9 Because each Convent within the Order of Our Lady of Charity was autonomous, the structure of the Order did not lend itself to the expansion of Convents/communities of Sisters that followed Sr Mary Euphrasia

1 GSC 1210.
2 GSC 580.

Pelletier's foundation of the first Good Shepherd community in Angers. She therefore sought and was given permission by the Vatican in 1835 to form a new congregation known as the Congregation of Our Lady of Charity of the Good Shepherd. Convents/communities of Sisters were established to respond to needs and to provide services to women and girls.

10 By the time of Sr Mary Euphrasia Pelletier's death in 1868 she had founded 110 communities across the globe. She was canonised in 1940 as Saint Euphrasia Pelletier. This module was solely concerned with those institutions run by the Order of Charity of the Good Shepherd before the amalgamation. That Order was commonly referred to as the Good Shepherd Sisters.

The Structure of the Congregation

11 The Good Shepherd Sisters are an institute of Pontifical Right directly accountable to the Vatican, with its own Superior General, and a General Chapter that meet every six years. Its Congregation was divided into a series of provinces, each with a Provincial Superior assisted by a Provincial Council.

12 The Superior General and provincial superiors would make regular visits to the various communities. The Superior General would visit each province every six years, and a Provincial Superior would make regular visits to the various communities within her province.

13 A separate Irish Province covered the whole island of Ireland. It contained a number of communities and services operating in Limerick, Dublin, Cork, Waterford and the three communities in Northern Ireland which we consider in this chapter. Each local community had a local leader known as the Mother Superior who was assisted by Council of Sisters from her community.

14 As in the case of other Roman Catholic religious orders investigated by this Inquiry, namely the Sisters of Nazareth, the Sisters of St Louis, the De La Salle Order and the Norbertines, the Good Shepherd Sisters were entirely separate in their management and financial structure from any diocese in which their communities were physically located, although they required the permission of a diocesan bishop to open a house in his diocese.

15 The Good Shepherd Sisters first came to Ireland around 1848. They came to Belfast in May 1867 at the invitation of the then Roman Catholic Bishop of Down and Connor who wrote to the Provincial in Limerick asking the

Congregation to send sisters to Belfast to operate a home for women and girls at Bankmore House adjacent to the River Lagan. This had been set up in 1860 by the Sisters of Mercy. They were primarily a teaching order and found they were unable to devote sufficient time to the Bankmore operation.

16 In October 1869 the Good Shepherd Sisters acquired new premises at Ballynafeigh at the top of the Ormeau Road in Belfast. The new premises, which we describe in greater detail later in this chapter, included laundry facilities.[3] The purpose of the laundry was said to provide income for the running of the facilities, and a way of offering work training to those in the care of the Congregation, as even after the introduction of the Welfare State they received little financial assistance, so the majority of admissions were private.[4]

17 In 1919 some sisters from Belfast moved to Londonderry to form a community in the city. A large mansion known as Bellevue House on the Dungiven Road in the Waterside area of the city, together with nineteen acres of land, was acquired following discussions with the then Bishop of Derry.[5] At the time of this purchase, plans were already underway to build a hostel and a laundry on the Dungiven Road site.[6] The Convent and home was opened in early 1921.

18 The Good Shepherd Sisters came to Newry, Co Down in 1944 following the purchase of Moorevale House on the Armagh Road. The building became habitable from 1945 and a new laundry was constructed and opened on the site in 1947.[7]

19 It will become apparent later in this chapter that the Good Shepherd communities in Northern Ireland operated a number of different services and facilities on each of their three sites at different periods, and we will describe these as necessary under the heading of each house in due course. We will describe the allegations made in relation to each of these three locations when we deal with each location. However, there are several themes which are common to each of the three houses, and we will deal with these first.

3 GSC 5013.
4 GSC 5026.
5 GSC 5029.
6 GSC 5030.
7 GSC 453.

The Objectives of the Good Shepherd Sisters

20 Because the Order was semi-enclosed before the changes brought about by the Second Vatican Council, and as such only permitted to undertake work outside the convent if the consent of the local bishop had been obtained, until the time of the Council those sisters who engaged in social work did so within a residential setting.[8]

21 From the arrival of the Good Shepherd Sisters in Ireland in 1848 the primary objective of their institutions was caring for women and children who had fallen into social or financial difficulty.[9] This was achieved in various ways, not all of which involved the provision of residential accommodation. As we shall see when we consider each of the three homes investigated in this module, in Northern Ireland this took a number of forms, not all of which were provided by each community in each location. Some of these are listed below.

- Residential centres for women and girls.
- Mother and baby homes for unmarried mothers.
- Laundries.
- An emergency night shelter for women and girls.
- Residential homes for teenage girls.
- Hostels for teenage girls moving from Good Shepherd care services.
- Youth clubs.

Ages of Girls in Good Shepherd Institutions

22 The references to "women and girls" require some clarification. While the Good Shepherd Sisters have informed the Inquiry that approximately 4,287 women and girls (excluding members of the Order) were cared for in their communities in Northern Ireland between 1922 and 1995,[10] it is clear that the majority were women over eighteen, and as such outside the Inquiry's Terms of Reference. Many of the Order's records and documents simply refer to women of all ages as "girls", and this has to be borne in mind when considering how many females under the age of eighteen (and so within our Terms of Reference) were resident within a particular institution at any given time.

8 GSC 582.
9 GSC 583.
10 GSC 529.

23 Because the surviving records do not always distinguish between females who were over or under eighteen at a given time, it has not always proved possible to establish the exact number of girls who were under eighteen residing in each institution at any one time, or how many of those under eighteen were under school leaving age. However, it does appear that the number of girls under eighteen were a small proportion of the total number of females resident in each institution, although the numbers varied from time to time. The number of girls below school-leaving age (which was fifteen for most of the period with which the Inquiry is primarily concerned) was smaller still, often only four or five in a house at any one time, although again the numbers fluctuated.

24 In this context it is important to bear in mind that the girls in these institutions fell into two groups. During the period when the applicants who engaged with the Inquiry were in these institutions the school-leaving age was fifteen. Girls in these institutions who contacted the Inquiry and were over that age sometimes, though not always, worked in the laundries or in other positions within the Good Shepherd community. Had they not worked in the laundries or other posts they would in the normal way have had to seek employment elsewhere or, in some cases, continue in education.

25 Girls who were under fifteen and had not reached school-leaving age were in a completely different position. Had they not been in a Good Shepherd institution then they would normally have been in a children's home of the type provided by the Sisters of Nazareth or, in some instances, in a children's home in the statutory sector. If placed in a children's home they would have lived in a completely different environment, which should have been completely child-centred. There were Good Shepherd Institutions which were completely child-centred such as the Sacred Heart Home in Belfast, and later the Adolescent Centre in Belfast. One of the issues for the Inquiry in this module is why children under school-leaving age (fifteen years old) were in Good Shepherd institutions which were not completely child-centred.

Siblings

26 The Good Shepherd Sisters emphasised in their written and oral evidence to the Inquiry that they were very aware of the desirability to avoid sisters being separated from each other, and so there were occasions when they accepted a significantly younger child in order that sisters would not be separated.

Changing Names

27 The Good Shepherd Sisters accept that at one stage it was their policy to change the names of women and girls upon their admission to one of their homes. The Sisters advised that the practice fell into abeyance in the early 1960s. They explained that they did not pry into the past of anyone, and no judgement was made as to what they had done before, or why they had ended up with the Order. The reason for changing the person's name was to protect their privacy and provide them with some degree of protection and confidentiality.[11] This practice appears to have applied equally to women over eighteen and to girls under eighteen and we understand may have been a widespread practice in mother and baby homes, although these are outside our terms of Reference. Although well-intended, this practice caused considerable distress and confusion to those affected. We considered that the practice continued longer than it should have done, and represented poor practice on the part of the Sisters.

Laundries

28 For many years, laundries were a very significant aspect of the work of the Good Shepherd Sisters in each of the three locations considered in this chapter. Those laundries generated a reliable source of income to pay the costs of care in the absence of state maintenance payments prior to the development of the Welfare State, or inadequate maintenance payments following the development of the Welfare State.[12] In their heyday these were substantial enterprises, taking in laundry from commercial and domestic customers, as well as dealing with the laundry needs of each community within the Order. For example, during the Second World War the Good Shepherd laundry in Londonderry secured the contract for all the military laundry in Northern Ireland, including that of the Americans at the local naval base.[13] A very large proportion of the females who lived in each community consisted of women over the age of eighteen, some of whom worked in the laundries for many years.

29 As will appear when we consider each location in turn, the Inquiry has sought to establish how many girls under eighteen worked in these laundries, and why.

11 GSC 341.
12 GSC 5809 and 5841.
13 GSC 5032 and 5492.

Corporal Punishment

30 It was a fundamental tenet of the Good Shepherd Sisters that they were never to strike children. While the Congregation accepted in their closing submissions that people do not always adhere to the high standards expected of them, from as early as 1897 it was the written policy of the Congregation that no corporal punishment should be administered by a Good Shepherd Sister against any person in their care, regardless of whether or not that was permitted by the law or statutory regulations in any jurisdiction within which the Congregation was operating.

31 In 1943 the Congregation's instruction manual entitled *Practical Rules for the use of the Religious of the Good Shepherd for the Direction of the Classes*, (the Practical Rules) emphasised that:

- It was forbidden to strike children.
- Children should never be deprived of food.
- If it was necessary to separate a child from her companions the child should never be shut up alone.[14]

32 The 1943 Practical Rules also emphasised that:

- Children should rarely be fatigued by any form of penance that they were required to undergo.
- Long penances were unprofitable.
- Penances should not be prolonged excessively.
- Penances should not be given too frequently.

33 The Congregation has said with some justification that the Practical Rules of that time could be legitimately described as enlightened and child focused at a time when corporal punishment was lawful, authorised in Northern Ireland by statutory regulations, and very frequently used in schools and families.

Not Turning Anyone Away

34 Sr Ethna McDermott emphasised that it was a fundamental tenet of the Good Shepherd Sisters that they would never turn anyone away who came, or was brought, to them in need of their help. On occasions this meant that they accepted children who were brought to them by social

14 GSC 555.

services or the police, even though the Sisters may not have been able to make satisfactory provision for the individual in question, at least in the short term.[15] The Inquiry has been provided with a handwritten note from a departmental file with a list of those in the Good Shepherd Home in Londonderry between 1960 and 1973, which appears to have been prepared by an official in the Ministry of Home Affairs and bears out what Sr Ethna said. The author noted that "Stranded young girls who come to their door, or who are brought by police are accommodated."[16] In 1973 Mr Kirkpatrick of the DHSS noted that:

> "Good Shepherd (as has happened in the past) have a policy whereby they will not refuse people in need no matter what their religion is".[17]

The Good Shepherd Sisters in Belfast

35 The Inquiry heard evidence from three applicants in person, and received a statement from a fourth who was ill and unable to attend in person, relating to their time in Belfast. We also received statements from two women who came forward to the Good Shepherd Sisters to describe their happy memories of their time in the care of the sisters in Belfast. As well as the evidence of Sr Ethna McDermott on behalf of the Congregation, we heard from a number of sisters who lived and worked in the Belfast community at various times.

36 Before considering the evidence of all of these witnesses, it is convenient to describe the various facilities on the Belfast site and their history, as some buildings were put to different uses during the period with which the Inquiry was concerned.

37 At various times from 1922 onwards the Good Shepherd Sisters had several different facilities located on a large eight-acre site at the top of the Ormeau Road in South Belfast. This was opposite the large Nazareth House complex of the Sisters of Nazareth located at the junction of the Ormeau and Ravenhill Roads which we have considered in Chapters 8 and 9.

38 At various times within the Good Shepherd complex there were eight different facilities. Some of these changed over the years or were in different buildings. Three of these are not directly relevant to this chapter.

15 Day 194, pp.45, 55 and 56.
16 GSC 5327.
17 GSC 5326.

These are the convent occupied by the Contemplative Sisters, the chapel and the Marianville Mother and Baby Home. Marianville operated between 1950 and 1990.

39 A facility that is relevant, although it was not a residential facility, is the St Mary Euphrasia Youth Club. This was set up by the Good Shepherd Sisters in 1951 and was located beside the Adolescent Centre, and is relevant because it is one of the practical ways the sisters sought to provide for the young people in their care. It is clear from what we have heard that the youth club was a very popular facility where girls from the Good Shepherd and young people from the neighbourhood could meet and socialise on a number of nights each week. The youth club was fondly remembered by many, and such was its popularity that not being allowed to attend it was regarded as a severe punishment.

40 Tragically, like so many organisations and facilities in Northern Ireland it was severely affected by the violence in the 1970s. A seventeen year-old Protestant boy who was a member of the youth club was murdered, presumably because of his association with a Catholic organisation. A history of the Belfast community described the Mass offered for the repose of his soul as "one of the most moving celebrations ever to take place in our chapel".[18]

41 On another occasion a car bomb was left outside the club one night, but fortunately caused little damage, and the club was able to open the following night.

42 In 1974 Michael Brennan, a youth leader in the club, was shot in the club while he was coaching table tennis by a terrorist group calling itself the Protestant Action Force. He died in hospital from his wounds. As a result, the youth club closed for almost a year, but it later reopened. However, by 1980 it had been transferred to a new building nearby and was managed by a committee of the Holy Rosary Parish.[19]

43 The terrible events described above that affected the youth club illustrate the violence from which the Good Shepherd Sisters sought to protect the children and young people in their care in each of their locations, and not just in Belfast, a concern which may have been wrongly interpreted by some of the children and young people as an example of a repressive and confining attitude on the part of the sisters.

18 GSC 5020.
19 GSC 1081 and 1082.

St Mary's

44 St Mary's was located in a large block situated beside the church and the convent. From the opening of the Convent in 1867 the Sisters provided residential accommodation for women and girls. A laundry was opened on the St Mary's site and operated until 1977 providing work for women. Although the great majority of those who lived and worked in St Mary's were over eighteen, it is clear that some teenage children also lived and worked there. The Inquiry heard from three applicants who did so between 1962 and 1966 (HIA 387, HIA 175 and HIA 124). We also received a statement from HIA 377 who was too ill to attend in person.

The Sacred Heart Children's Home

45 The Sacred Heart Children's Home operated between 1922 and 1962 and was located in a large building immediately beside St Mary's. The Sacred Heart provided residential care for children between the ages of two and sixteen, and was registered as a voluntary children's home by the Ministry of Home Affairs under the Children and Young Person's Act (Northern Ireland) 1950 on 29 June 1950.[20]

46 During the 1950s the Sacred Heart Home was registered for 33 girls of all ages.[21] In 1956 the Ministry of Home Affairs divided the certificate for the voluntary children's home into three parts.[22] This recognised that the Sacred Heart was different to St Mary's and to the Marianville Mother and Baby Home, both of which had also been included in the original registration certificate.[23]

47 The Sacred Heart Home was inspected by Miss Kathleen Forrest of the Ministry of Home affairs in 1953, and she described it in favourable terms:

> "Good material conditions. Could perhaps do with more play equipment, but would, I think, buy anything suggested to them. Have singing, elocution, dancing classes and girls go out to ordinary schools and to do shopping for Home. Not short of money I think."[24]

20 GSC 5009.
21 GSC 5005.
22 GSC 5009.
23 GSC 6876-78.
24 HIA 1463.

48 While it was registered to accommodate 33 girls of all ages,[25] in the mid-1950s the annual returns to the Ministry of Home Affairs recorded fewer girls in the Sacred Heart than that,[26] and the numbers gradually declined from 30 girls in 1953 to 23 in 1956, and 24 in 1957.[27] Unfortunately the limited statistics available for this period do not reveal what were the numbers of children under the school-leaving age (which was increased from fourteen to fifteen in 1957), and those who were over the school leaving age but under eighteen.

49 SR 283, who worked in the Sacred Heart Home from 1960 until it closed in 1962, remembered that the home took children between the ages of two and sixteen. She told the Inquiry that the sisters knew the importance of keeping sisters together, and recalled two incidences where this occurred during her time in the home. One girl was about seven or eight and her sister ten. In the other instance the younger sister was maybe thirteen and went to St Monica's Secondary School nearby. She thought her elder sister was perhaps thirteen to fifteen and went to St Dominic's Grammar School, which was in a different part of the city.[28]

The position between 1962 and 1970

50 The Sacred Heart Home closed in 1962, and in due course was replaced by the Adolescent Centre which opened in the same premises in 1970. Between the closure of the Sacred Heart Home and the opening of the Adolescent Centre the sisters told the Inquiry that they believe the older children who were ready to move into independent living arrangements moved out of care. They believe that those who were not ready for such a move, and this would inevitably have included those children who were still under the school-leaving age of fifteen, became the responsibility of the sister in charge of St Mary's. Whilst it is unclear where the younger children slept after the Sacred Heart Home closed, it seems likely that for part of the time at least they were accommodated in the St Mary's building. It had been extensively refurbished over a six-year period between 1957 and 1963, and the dormitories there had been sub-divided into cubicles.[29]

25 GSC 5005.
26 GSC 7052.
27 GSC 7049.
28 Day 193, p.58.
29 GSC 1177.

51 The sisters have described how from 1968 onwards those teenagers who were regarded as being part of the "St Mary's class" lived in the building that had previously been the Sacred Heart Home. That confirms the inference that between 1962 and 1968 those children lived in St Mary's with the older women who lived there. The St Mary's class was regarded as a separate and distinctive group. As there was not a separate kitchen in the Sacred Heart building, those girls were served their food in the St Mary's canteen kitchen and then carried their food along an internal corridor to the dining room or refectory in the Sacred Heart building where they ate their meals together.[30]

Conditions in the early 1960s

52 Two applicants to the Inquiry were in the care of the sisters in Belfast during the period between the closure of the Sacred Heart Home in 1962 and the return of children to that building in 1968 or 1969. They were therefore within the group described by the sisters as being part of the St Mary's class. HIA 387 was thirteen when she arrived in June 1962 and left fifteen months later in September 1963 aged fourteen and a half. She was unique among the applicants in this module in having been in all three of the homes considered by the Inquiry in this chapter, and we will consider her experiences in the homes in Londonderry and Newry later when we consider the evidence relating to those homes.

53 Before she came to the Good Shepherd Sisters in Belfast, HIA 387 had been in the care of the Sisters of Nazareth in Belfast, and she gave evidence about her time with the Sisters of Nazareth on Day 92 of the Inquiry. Her recollection is that she came straight to the Good Shepherd Sisters from the Sisters of Nazareth across the road in 1962. Whilst the Sisters of Nazareth records show her as leaving their care in July 1961 to return to her family, HIA 387 has no recollection of being at home, or elsewhere, between her time with the Sister's of Nazareth and when she arrived with the Good Shepherd Sisters in Belfast in June 1962. Be that as it may, she says that when she was with the Good Shepherd Sisters in Belfast she did not continue to attend St Monica's Secondary School as she had before, and she says she was placed in the laundry to work.

54 As she was under the school-leaving age of fifteen throughout her time in the Good Shepherd Sisters at Belfast she should have been attending

30 GSC 1178.

school. Returns by the Good Shepherd Sisters to the Ministry of Home Affairs showing the number of children in their care on 31 March 1963 record that there were four girls in the home who were between the ages of five and fourteen,[31] all of whom were of compulsory school age (that is five to fifteen) and were attending school. These figures suggest that as HIA 387 was in the care of the sisters in Belfast at that time it is highly likely that she was attending school. We believe that she is mistaken in her recollection that she did not attend school whilst in the care of the Good Shepherd Sisters in Belfast.

55 She described to the Inquiry how she was made to work unpaid in the laundry, although the Good Shepherd Sisters say that no one as young as thirteen would have been allowed to do so. No one else who was in the Good Shepherd Sister's complex in Belfast and who was as young as HIA 387 has come forward to the Inquiry to say that they worked in the laundry there when they were under school-leaving age. HIA 377 came to Good Shepherd School in April 1963, a month after her fifteenth birthday. Because of illness she was unable to give evidence in person, but in her witness statement she described being told to help another girl fold laundry.[32]

56 SR 283, who worked in the Sacred Heart Home from 1960 until it closed in 1962, told the Inquiry that she had no recollection of children who were about twelve to fourteen working in the laundry.

57 Because we are satisfied that HIA 387 attended school during her time in the Good Shepherd in Belfast, as a school girl she could only have worked in the laundry after school hours during term time and before the work in the laundry stopped for the day, also at weekends or in the holidays. There is a possibility that she has conflated her experiences in Belfast with her experiences in the laundry in Londonderry and in Newry, where she also spent some time.

58 She has described an incident she says occurred when she was aged fourteen and in the Good Shepherd in Belfast. She says she climbed over a wall into an orchard in the nun's garden. She was caught there by a priest who took her to the sacristy, told her she was wicked and then raped her. This happened on a Saturday, and the next day being Sunday she refused to go forward to take Holy Communion. When asked by a nun why

31 GSC 5844.
32 GSC 081

she would not go forward she explained that she would not eat "anybody's body from soiled hands". When the nun asked her what she meant she told the nun what the priest had done to her, whereupon the nun slapped her and told her she was a little liar. She was then put to work in the worst part of the laundry where all the soiled clothes were. Within a week of telling the nun what had happened she said she was moved to another Good Shepherd Home in the country, where there was a railway track at the back, which she now believes to have been the Good Shepherd in Newry. The Good Shepherd Sisters pointed out that in fact she went from Belfast to their home in Londonderry for eight months between 30 September 1963 and 1 June 1964, and from Londonderry she went to their home in Newry.

59 Although the Good Shepherd Sisters initially told the Inquiry there was no orchard in Belfast, on further investigation it was recalled that the Contemplative Sisters had a small orchard and vegetable garden bounded by a high wall on one side and by high hedges on another. According to a former caretaker, this was accessed through an arched opening in the hedge.[33] A map prepared by the Good Shepherd Sisters for the Inquiry shows this area as being some distance from the chapel where the sacristy was. A possible inference from this layout is that the description of the place where HIA 387 says she climbed over a wall is not easy to reconcile with the layout of the Good Shepherd Sisters' orchard. In addition, as the sacristy was some distance away it is somewhat unlikely that a priest would have been in the Contemplative Sisters' orchard or would have been able to take her to the sacristy unobserved.

60 We have also taken into account that the layout described by HIA 387 much more closely resembles the orchard attached to the presbytery of the former Holy Rosary Church, which adjoined the Sister of Nazareth premises on the opposite side of the Ormeau Road where she had been before.

61 We carefully considered all these matters, and whilst we accept that such an incident may have occurred, we have been unable to determine whether it occurred whilst HIA 387 was in the care of the Good Shepherd Sisters or in the care of the Sisters of Nazareth.

62 There are very few figures available which show the actual number of teenagers who were in the Good Shepherd in Belfast at the same time

33 GSC 1211.

as HIA 377. In January 1964 out of 123 females, only ten were "welfare cases", ie children placed by local authority welfare departments and who were therefore under the age of eighteen. Of the ten, only four were under fourteen and all were said to be attending school. In March 1965, of 26 girls recorded as living in St Mary's, 23 were between fifteen and eighteen and three were fourteen and under. Whilst we know that in March 1966 there were sixteen welfare authority children in St Mary's and in March 1967 there were thirteen, it is not possible to establish in each year how many were under fifteen, or between fifteen and eighteen. Nor is it possible to establish whether these figures represent the total number of girls in St Mary's who came into either age group in those years, because there may well have been other girls in both age groups who had been placed privately. All that can be said with confidence is that for most of the time when HIA 377 was in the St Mary's class there were several other girls of a broadly similar age there at the same time. This is because we know there were twenty girls in 1965 in the fifteen to eighteen age group, and it is probable that there were girls at the same age in both 1966 and 1967.

63 HIA 377 was the only other person who was in the Good Shepherd in Belfast during the 1960s who has contacted the Inquiry. She arrived in April 1963 shortly after she passed her fifteenth birthday, and remained there until she left in April 1968 aged eighteen. As such she overlapped with HIA 387 and so would have been one of the teenagers who formed the St Mary's class.

64 HIA 377 was moved to the Good Shepherd in Belfast by Tyrone County Welfare Committee after she ran away from Coneywarren Children's Home outside Omagh, Co Tyrone. She described asking SR 285 and Mrs McFadden (the social worker who brought her to Belfast) how long she would be staying, and was told by them until she was eighteen. SR 285 told her she would not be allowed out, but her brothers could visit her. Her brothers took it in turn to visit her every week and brought her toiletries. They also brought her grandmother to see her. After about eighteen months, her brothers were allowed to take her out for a few hours on Saturdays.

65 While we accept that family visits were facilitated, we are satisfied that at this time the Good Shepherd Sisters discouraged the girls in their care from leaving their premises, and that in the earlier years there was a practice of containment of girls, although as HIA 377's experiences

demonstrated, older girls were not prevented from going out if they were accompanied. As we shall see when we consider the Adolescent Centre, the practice appears to have become more relaxed by the early 1970s. However, in 1963 when HIA 377 arrived we accept that a more restrictive attitude prevailed, no doubt because at that time the order was still semi-enclosed, and changes in attitude that flowed from the Second Vatican Council were still to come.

66 HIA 377 complains that the nuns did not care for, or show any interest in, her education, but it has to be remembered that she was past school-leaving age when she arrived in Belfast. As we have already described, there is evidence that shows that at this time the Good Shepherd Sisters in Belfast ensured that children below school-leaving age attended schools.

67 Although HIA 377 says she suffered from poor health during her time with the Good Shepherd Sisters in Belfast, it would seem from her account that she received medical treatment at Belfast's Mater Hospital.

68 She describes the food as very poor, but hers is the only complaint about the food.

69 The descriptions of the laundry given by both HIA 387 and HIA 377 portray the work as hot, physically demanding and tiring. Both say they were not paid. We accept that was the case at that time. Irrespective of whether they were above or below fifteen, we considered it was unacceptable for such young girls to be **expected to do industrial work of this type. We considered this amounted to systemic abuse**.

70 HIA 377 describes how she was slapped by the nuns on two or three occasions, and was once slapped hard on the hands with a ruler. However, she describes hitting back on each of these occasions. We accept that such occasions were not widespread, systemic or condoned, and we do not regard them as sufficient to constitute systemic abuse.

71 HIA 377 also describes how on two occasions older women who she thinks lived in the convent made sexual advances to her in the boiler house. Whilst these amounted to sexual abuse by the individuals concerned, they were not reported by HIA 377 to anyone in authority, and as they appear to have been opportunistic and only occurred twice, we do not consider that they can be regarded as amounting to systemic abuse.

Roseville Hostel

72 In 1967 the Good Shepherd Sisters opened Roseville as a hostel to provide transitional living arrangements for those girls starting their first jobs, or who were leaving full-time care and starting to move into independent living. Roseville was located in a separate building on the Carolan Road side of the complex between the Sacred Heart Home on one side and the Marianville building on the other.[34] As the title "hostel" implies, Roseville was designed to cater for those who did not require strict supervision, which would in any event not be practical as many of those were starting their first jobs and went to employment outside the hostel.[35] Residents paid for their bed and board. The hostel had two bedrooms with a sister living in each, and two bedrooms of a larger dormitory type, each with separate individual cubicles for four girls.[36] Roseville closed in 1975.

73 HIA 175 was the only applicant to the Inquiry who had been in the hostel. When she had the opportunity to go through some social services and other records obtained by the Inquiry with Mr Aiken, Junior Counsel to the Inquiry, she accepted that her memory of dates and events was not accurate. She came to live in the hostel in November 1971 aged fifteen and a half, although she continued to work as a residential nursery assistant in St Josephs Baby's Home run by the Sister's of Nazareth across the road. During the succeeding months she did not return to the hostel on a number of occasions. By the end of February 1972 she was working in the laundry and by now was aged fifteen and nine months.

74 She did not like the laundry work, and her social worker, who saw her frequently, tried to arrange alternative accommodation for her in lodgings. HIA 175 did not like the suggested accommodation, so she was allowed to stay on in the hostel. However, a week later she refused to return to the hostel and was removed under a Place of Safety Order to St Joseph's Training School at Middletown, Co. Armagh. The application for a Place of Safety Order was refused and after a month at St Joseph's she was returned to Roseville. It seems that throughout this unsettled period she was very anxious to live at home with her mother, although home conditions were not satisfactory.[37] She did not settle in the hostel and was returned to Middletown under another Place of Safety Order in August 1972, and

34 GSC 379
35 GSC 389.
36 GSC 399.
37 GSC 224.

a Training School Order was made three weeks later committing her to St Josephs' where she was very happy.

75 Having seen the records, she only had two recollections about her time in the Good Shepherd in Belfast which were of concern to the Inquiry. The first was that she recalled being painted all over with a stinging substance by SR 196. When the records were explained to her she accepted that this may have been done because of a medical condition for which she received treatment at the time. The documentation from the records of the Health and Social Care Board[38] refer to her having had a medical condition "for which she attended the doctor". The Sisters did not accept that SR 196 would have engaged in administering or applying any medical treatment to any resident in Roseville. However, HIA 175 believed it was applied by SR 196, but she was anxious to emphasise that, whatever the substance was, it had not been applied for a sexual reason or as a punishment.[39] We are satisfied that there was nothing improper or abusive in this episode.

76 The other matter related to an occasion when she recalled all of the girls of her age being taken one at a time into a room by SR 196 where a priest then asked each of them whether they were a virgin. Such an exploration of the sexual history of HIA 175, or any other girl, by a priest in such circumstances was entirely inappropriate, and we regard such a question in those circumstances as unacceptable and abusive. However, whilst it is clear from her evidence that HIA 175 does not regard the Good Shepherd Sisters as being responsible for the question, or for the way it was asked, HIA 175 stated that SR 196 was present during the questioning. In their response to the Inquiry Warning Letter the Sisters did not accept that such an incident could have happened, or if it did, that they were responsible for it. **However we are satisfied there was such an episode and the failure of SR 196 to intervene and stop the questioning was a systemic failing.**

The Adolescent Centre

77 In 1969 the building previously containing the Sacred Heart Home was renovated and opened in 1970 as the Adolescent Centre. It operated until June 1982, when it closed because of a fall in the number of admissions.[40]

38 GSC 223.
39 Day 190, pp.34 to 36.
40 GSC 6342.

It was a residential centre with accommodation for up to 21 teenagers in twelve individual rooms, and there were also three small dormitories, each with up to three beds. It was intended to accept children who were twelve to seventeen, although one resident said that the congregation made an exception and kept her nine-year-old sister so they could remain together. GSC 21 was the sister in charge throughout its existence. It was sometimes known as "The Teenage Unit".

78 All the girls in the Adolescent Centre were placed there by social services. Those who were of compulsory school age went out to school, either to St Monica's Secondary School, which was a ten minute walk away, or by bus to St Dominic's Grammar School on the Falls Road. Although no records have survived, one of the sisters who worked there recalls files being kept on the progress of each child, and that regular reviews of each child were held with social services. Regular contact took place with members of their families, contacts which were encouraged and facilitated on a supervisory basis if necessary, where this was recommended and supported by the teenager's social worker.[41]

79 From the mid-1970s a sister was appointed to the Centre to prepare all the meals for the teenagers, although the girls were encouraged to help her with shopping and with the preparation of evening meals, they were also shown how to cook some dishes. All of this was to show them how to budget, select fresh vegetables and cook for themselves when they left care.

80 Those who had homework were sent to do it after school. If they had no homework they could play outside or relax in the sitting room where there was a TV and a record player. Reading of novels was encouraged.[42]

81 HIA 124 was in the Adolescent Centre from 1971 when she was thirteen and nine months until 1974 when she was sixteen and a half. She was placed there by social services. As in the case of HIA 175, Mr Aiken took her through the various records relating to her which had been obtained by the Inquiry. This process helped her to be aware of, and to understand, various matters relating to her time in the Adolescent Centre. She told the Inquiry that she did not have any bad memories of her treatment at the hands of the Good Shepherd Sisters,[43] something that was in marked

41 GSC 404.
42 GSC 397.
43 Day 190, pp.10-11.

contrast to her recollection of her time with the Sisters of Nazareth, which she described when she gave evidence on Day 96.

82 She quickly became very attached to GSC 21. When she made her witness statement she had been critical of the way her enuresis had been dealt with, but she now understood that the sisters saw to it that she received medical help from the specialist and that the sisters dealt with the problem in a more sympathetic way than she had appreciated. She also now understood why the Good Shepherd Sisters did not take her back after she had been admitted to a psychiatric hospital after taking a second overdose. She explained that seeing her records had cleared up a lot for her, and she saw the Good Shepherd Sisters had done a lot for her.[44]

83 The favourable views of their times in the Adolescent Centre to which HIA 175 and HIA 124 came after seeing their records was in keeping with the views expressed in witness statements by GSC 42, who was in the Centre from 1976 to 1980 and GSC 41, who was there for five years from the end of 1973 or the beginning of 1974. Two points stand out from their statements. The first was that GSC 21 insisted that girls from the Adolescent Centre were given money to buy lunch tickets at St Monica's so that they would not stand out from other girls by having free school meals or packed lunches. The other was that the youth club to which we have already referred was the focus of their lives, and if they misbehaved and were not allowed to go to the youth club "it was like the end of the world!"[45]

84 Looking at the Sacred Heart Home, the St Mary's class, the Roseville Hostel and the Adolescent Centre as a whole, it is clear that there was a very considerable change in the way the Good Shepherd Sisters approached residential care for the children in their care by the late 1960s. Not only were there greatly improved material facilities, but the Roseville Hostel and the Adolescent Centre were well run and provided a good standard of child care. These were examples of the Sisters' willingness to be flexible and innovative to respond to changing needs, and we commend them for doing so.

The Good Shepherd in Newry

85 The Inquiry heard evidence in person from two applicants. HIA 387 had previously been in the Good Shepherd in Belfast and we have already

44 Day 190, p.22.
45 GSC 294- 295.

referred to her evidence about her time there. She also spent some time in the Good Shepherd in Londonderry and we shall consider her evidence about that time later. HIA 202 also spent time in Londonderry after she had been in the Good Shepherd in Newry and we shall consider her time in Derry later. The third applicant was HIA 359 who was unable to give evidence in person due to ill health and we received her written statement.

86 Before considering their evidence, we describe the site and the facilities upon it at the Good Shepherd in Newry. The Newry site was the smallest of the three facilities run by the Good Shepherd in Northern Ireland with which we are concerned, and like them contained a number of separate facilities on the same site. There was a small farm of a few acres, a church and a convent for the sisters. A new laundry was built and opened in 1947. There were residential dormitories for women, that is ladies over eighteen, and teenage girls known as St Mary's Newry. Marianvale Mother and Baby Home opened in the 1950s and was co-located on the same site. Marianvale Mother and Baby Home provided accommodation for pregnant women, mothers and their babies.[46]

87 When considering the ages of the children under eighteen, as we have already explained it is necessary to distinguish between those under school-leaving age, and those above school-leaving age but below eighteen, for the reasons we have set out earlier. Originally there were four pre-fabricated buildings, two of which were dormitories, one was a kitchen and the fourth a dining room/refectory.

88 Distinct from St Mary's there was an entirely separate Marianvale Mother and Baby Home which closed in 1984. From 1973 a short-term Emergency Hostel was opened close to Marianvale. The hostel consisted of two bedrooms and shared kitchen, living, bathroom and toilet facilities. The hostel was for mothers and children in domestic violence situations, and the Sisters recall that it was run in conjunction with the local social services.

89 In later years the residential accommodation for the women and teenagers consisted of a dining hall, a recreation room, a room described as a community room, a common room, a kitchen, a TV lounge, bedrooms and dormitories. The convent as a whole was registered as a voluntary children's home on 16 February 1951, but was re-registered on 25 April 1956 to include the Marianvale Mother and Baby Home.

46 GSC 6892 and 6893.

90 Due to the very limited records that have been found it is difficult to establish how many girls under eighteen who are within our Terms of Reference were in St Mary's at any time, and how many of those were under school-leaving age. Prior to completion of the registration process, a letter of 7 September 1950 from the Northern Ireland Council for Social Services said only five or six girls in the fifteen to eighteen group resided in the home, and they were working in the laundry. The recollection of the sisters is that there were usually between three and six teenagers at any time, although the numbers fluctuated. In addition there were older women over eighteen. Whilst the home had accommodation for up to 36 girls of all ages (which included women over eighteen) in the 1950s the total was usually between 20 and 30 (including the teenagers) but the overall numbers declined significantly in later years.[47]

91 Statistical returns to the Ministry of Home Affairs for the four years 1953 to 1956 show one child in 1953, none in 1954, and two in 1956. An inspection by the Ministry of Home Affairs in June 1958 said there were two girls under eighteen, and a letter from the Ministry of 16 December 1959 said that there had been two girls under eighteen the week before.

92 Annual returns for a number of years in the 1960s show a slightly higher number of girls under eighteen in some years.

- 1963 – four (all over fifteen)
- 1964 – four
- 1965 – four
- 1966 – two
- 1967 – three
- 1968 – two

However, apart from 1963, it is not possible to establish if any of the girls were under school-leaving age.

93 The figures for the 1970s are limited to two occasions. An inspection on 22 June 1973 by Miss Hill recorded five girls, all between fifteen and eighteen. On 12 February 1976 Miss Forrest recorded that of 30 females "only five were in the younger age group". Whilst this does not expressly distinguish between those under and those over school-leaving age, it is probable that all five were between the ages of fifteen and eighteen, because Miss Forrest stated that the sisters:

47 GSC 460.

> "...would not normally take in school age girls because of travel difficulties, but have one fifteen year old girl in special circumstances."

The 'special circumstances' were not explained.

94 From the available, albeit limited, information it would therefore seem that in the 1950s there were often only two girls, and in the 1960s there were usually between two and four girls, and in the 1970s there were usually five girls. Although it may well be the case that during these decades all of the girls were above school-leaving age and under the age of eighteen, the absence of detailed information makes it impossible for us to be satisfied that in every instance there were no children under school-leaving age in the Good Shepherd in Newry.

95 In her "*Brief Impressions*" of the different Voluntary Children's Homes in Northern Ireland, which she prepared on 28 April 1953 and to which reference has already been made in this chapter, Miss Forrest described the Good Shepherd Convent Newry in the following terms:

> "Material conditions and equipment very good. Girls and women work in laundry, have all amusements laid on inside Home. Quite happy atmosphere in both places."

96 In her report on her visit to both the convent (that is the residential home) and the Marianvale Home on 22 June 1973, Miss Hill of the Ministry of Home Affairs described the arrangements for the girls in the residential home in terms which make it clear that some of those in the fifteen to eighteen year range were attending school.

> "Five girls were in the fifteen – eighteen years range, one of whom was in Special Care, while four were the responsibility of Welfare Authorities. One girl attends the Grammar School and another the Technical School in Newry. They are full-time students, but some other girls attend various classes in the Technical School."[48]

97 The three applicants who described their experiences in the Good Shepherd in Newry were there in different decades, HIA 359 being the earliest. She is now 79, and did not give evidence in person due to ill health. In her statement to the Inquiry she described how she came to the Good Shepherd in Newry from their convent in Limerick when she was about fourteen as she had suffered poor health, and she said she was told she was being sent to Newry because the air was fresher and healthier. She

48 GSC 6893.

recalled being sent to work in a hospital in Clonmel, Co Tipperary when she was seventeen or eighteen.

98 However the Good Shepherd Sisters records state that she arrived in Newry in January 1955, when she was seventeen and a half, and went to Clonmel in April 1961 when she was 23. The Good Shepherd Sisters point to three other matters which it was suggested indicated that HIA 359 may have confused her recollections of life in Newry with those in Limerick. The first is that although she referred to working in a bakery in Newry, there was no bakery there but there was in the Good Shepherd in Limerick.[49] The second is a recollection that there were "about 80 girls in the Good Shepherd in Newry". The Good Shepherd Sisters say that there were never as many females as that in Newry, but the laundry in Limerick was larger. It is correct that the Ministry of Home Affairs records referred to earlier show much smaller numbers in Newry in the 1950s, such as "36 girls of all ages" in 1953,[50] and "girls of all ages" would include women over eighteen. The third is a reference to Mother Good Shepherd teaching in the classroom, and SR 281 said that Mother Good Shepherd taught in Limerick, never in Newry.[51]

99 HIA 359 described being in a classroom for a while, but as she was over school-leaving age when she arrived in Newry this may be somewhat unlikely. She said the food was poor and she was always hungry. She described working in the laundry from the age of sixteen, being punished for mixing up orders in the packing room, being given a bad beating on the back of her legs by a nun and being slapped on the hands many times.

100 She described working on the small holding attached to the convent and picking potatoes, but that would have been a common practice at the time of the potato harvest in rural families.

101 She said she was paid £2.50 when she left Newry, although it is not clear whether this was money due to her for her work, or perhaps was to cover her journey until she arrived at St Joseph's Hospital in Clonmel.

102 Whilst not all of HIA 359's recollections of the way she was treated during her time in Newry were negative, for example there was an annual trip to the seaside. She also described going to hospital to have her appendix out. There were some complaints that were corroborated to some degree

49 GSC 336.
50 GSC 5006.
51 GSC 336.

by the evidence of SR 281 who was in Newry between 1957 and 1969, and again in 1970 to 1971.

103 The first of these was the practice of silence at meal times, relieved only by a nun reading from a book or newspaper. SR 281 accepted that silence during meals was something that was carried over from the sisters' own practice at meal times, although she said she tried to lighten the atmosphere by reading from a humorous book or from a newspaper. She said that whilst the sister in charge would sometimes say that the women could talk, this was her decision. She recalled the practice of silence at meal times stopping late in her time, which would suggest that the practice continued at least until the late 1960s.

104 The second related to the practice of changing names, something we have already seen was a practice in Belfast. SR 281 reiterated that this was to protect the privacy of the girls so that no one could pry into their backgrounds.

105 HIA 387 came to Newry in March 1964 aged fourteen and eleven months, and left six months later at the end of September 1964. She is the only applicant who describes her experiences there in the 1960s. She came to Newry from the Good Shepherd in Londonderry. She says that she was made to work in the laundry in Newry. She said she was not hit by the nuns when she was in Newry, but did not remember receiving any pay or pocket money while working in the laundry. Her principal concern was that when she left she was put on a train to Belfast without any preparation for life after living in care.

106 However, the Good Shepherd Sisters suggested that her reason for leaving was because she had a row with another woman, and that although her recollection was that she was put on a train to Belfast and ended up in East Belfast living on the streets, the Sisters say that she left at her own request and went to a job in the Mater Hospital in Belfast. HIA 387 said that she vaguely remembered staying in a hostel and working in the Mater Hospital.

107 The third applicant who described her experiences in Newry was HIA 202, who arrived in August 1973 a week before her sixteenth birthday and left five months later in January 1974 when she went to the Good Shepherd Sisters in Londonderry. She also recalled working in the laundry with older women, and did not recall being paid. She described the atmosphere in Newry as being more relaxed than that in the Good Shepherd in

Londonderry, although she did not recall being allowed out. She said that the food was all right, she was never physically abused, and while there she learnt the guitar.

108 She described how she became friendly with a nineteen-year-old boy who was the delivery boy for the laundry. Later he told her that the nuns would not let him see her, and in January she was told by the Mother Superior that he had died. She was so upset by this news that she ran away to England with two other girls. They were traced by the police and were brought back to the Good Shepherd in Newry. She described how she was given the option of returning to her home in Newry, but she felt that by placing her in the Good Shepherd her mother had deserted her so she went to the Good Shepherd in Londonderry and we will consider her experience there later. It is clear that this experience made a profound impact upon her and she describes how it has affected her throughout her life.

109 In the Good Shepherd in Newry amenities were provided for the teenage girls in the home, particularly in later years. There was a television, music lessons in their free time and at weekends, and they were encouraged to learn what were seen as useful skills such as embroidery and dress making. A house in Cranfield, Co Down was rented for holidays. SR 281 said that it was smaller than Belfast and she saw it as a family home where nuns interacted very simply and caringly with the girls.

110 Although we were satisfied that the practice of silence at meals, relieved only by a nun reading to them, and occasions when they were able to speak on days when that was permitted by the sister in charge, was a poor and outdated practice, we did not feel that the adverse effect was sufficient to amount to systemic abuse.

The Good Shepherd in Londonderry

111 Five applicants described their experiences whilst in the Good Shepherd in Londonderry. HIA 107 and HIA 211 were both there in the first half of the 1960s, although HIA 211 continued to live there until 1975. However, her experiences after she reached the age of eighteen in September 1963 are outside our Terms of Reference. HIA 387 was there in the same period. She came from the Good Shepherd in Belfast and spent five months in Londonderry before she went to the Good Shepherd in Newry. HIA 202 and HIA 7 were there in the 1970s. HIA 202 came from the

Good Shepherd in Newry, and we have already referred to her experiences there, and to the experiences of HIA 387 in Belfast and Newry.

Buildings

112 The laundry to which we referred in paragraph 28 was mechanised in the early 1960s.[52] A new chapel was opened in 1958. A new wing was built in the 1930s and was used as the Sacred Heart home for young teenagers until it was closed in 1952.

113 In the early 1970s part of this wing was adapted to provide modern hostel facilities for sixteen teenage girls aged fifteen to eighteen. This contained sixteen single rooms, four sitting rooms, a dining room, an office, bathrooms and a kitchenette for the preparation of snacks.[53] The work was completed in 1975 and the hostel became known as the "Bellevue Hostel". A report by Miss Hill of the Ministry of Home Affairs of her visit to the hostel in July 1975 described the unit as "functional, attractive and well-equipped".[54] The hostel appears to have been an initiative similar to the Roseville Hostel, which operated in the Good Shepherd in Belfast from 1967 to 1975.

Numbers

114 Although there was accommodation for up to 100 girls aged between fourteen and seventeen, in her, "*Brief Impressions*" report of 28 April 1953 Miss Forrest commented that the convent contained, "only a few teen-aged girls, the rest are older women".[55] Throughout the 1950s the number of girls under the age of eighteen fluctuated, as can be seen from the statistical returns for 1953 to 1957.

- 1953 – Thirteen over sixteen.
- 1954 – Ten over sixteen.
- 1955 – Two over sixteen.
- 1956 – Five over sixteen.
- 1957 – Four girls are recorded.

115 The number of girls below eighteen in the 1960s appears to have been broadly similar.

52 GSC 312.
53 GSC 5330.
54 GSC 5304.
55 HIA 1463.

- May 1962 – Twelve between fifteen and eighteen.
- March 1963 – Eight between fifteen and eighteen and two aged fourteen or under.
- March 1964 – Ten under eighteen.
- March 1965 – Five between three and eighteen, and three aged fourteen or under.
- March 1966 – Three under eighteen.

116 Of those listed in the returns of the 1960s some are described as "welfare cases" and were therefore placed by local authorities, so must have been under eighteen. In the late 1960s such figures as are available refer to "welfare" cases.

- March 1967 – Seven under eighteen.
- March 1969 – Eight welfare children.

117 The few figures available for the 1970s suggests that the number of girls under eighteen was falling, despite the opening of the Bellevue Hostel by 1975. In September 1973, Miss Hill of the Ministry of Home Affairs found only two girls under eighteen, and in July 1975 she only found three girls. The small number of girls in the hostel may explain the willingness of the sisters to consider (and the DHSS to sanction) letting four of the rooms in the hostel to the nearby Altnagelvin Hospital to accommodate nurses.[56] By December 1982 there were only two girls resident in the hostel.[57] The small number of girls in Bellevue Hostel throughout its existence may explain why, like the Roseville Hostel in Belfast, it had a relatively brief existence. It was deregistered as a children's home on 27 February 1984.[58]

118 Over the three decades covered by the evidence of the applicants to the Inquiry it would seem that those under eighteen made up less than ten percent of the females resident in the Good Shepherd in Londonderry, (excluding of course the Good Shepherd Sisters themselves). Before the opening of the Bellevue Hostel it appears to have been the practice, as in other Good Shepherd institutions, to describe the accommodation for the teenage girls and adult women who lived in the convent as St Mary's.

56 GSC 5304.
57 GSC 6700.
58 GSC 5009.

The Decision to send HIA 107 to the Good Shepherd in Londonderry

119 HIA 107 was just three days short of her twelfth birthday when she was admitted to the Good Shepherd in Londonderry by a Fit Person Order made by Strabane Juvenile Court under Section 13 of the Children and Young Persons Act (Northern Ireland) 1950. She and two other children of similar ages were sent by the Juvenile Court to the Good Shepherd in Derry at the end of 1960. GSC 17 was already there when HIA 107 and GSC 16 were sent there. In HIA 107's case the court order states that she was committed to the care of the Good Shepherd Convent in Londonderry until she was eighteen on the basis that she was in need of care and protection because she was a child "who having a parent not exercising proper care and guardianship is exposed to moral danger".[59]

120 It would seem from her account, and from the few court documents now available, that HIA 107 and her two companions came to the notice of the RUC in Strabane, Co Tyrone, because a number of men had taken advantage of their youth to give them money in return for various sexual acts. Although HIA 107 says social services were involved, there are no contemporary records to confirm that Tyrone County Welfare Committee, which was the local welfare authority for Strabane at that time, was involved when HIA 107 and her companions were sent to the Good Shepherd (although there are records that show they were involved some years later). We can only infer that the RUC brought the applications because their investigations led them to believe that the home circumstances of all three children were such that they would not be properly looked after, and prevented from being involved in such matters again, if they were to remain in the care of their parents.

121 The Juvenile Court must have been satisfied that was the case when it sent HIA 107 (and presumably the two other girls also) to the Good Shepherd in Londonderry. We appreciate that to place three young girls who, through no fault of their own, had been involved in sexual behaviour in the same children's home might have created difficulty for the home. There is no evidence to explain why the Juvenile Court did not take what we believe to have been the only sensible course in those circumstances and split up the children by sending them to different children's homes. Coneywarren Children's Home in Omagh, Co Tyrone, and the Sisters of

59 GSC 3015.

Nazareth Home in Bishop Street, Londonderry, would have been obvious choices for at least two of the children.

122 As the Good Shepherd Convent was named in the court order in the case of HIA 107, and because the other two children appear to have been sent there as well at approximately the same time, we can only infer that either the police or the court approached the Good Shepherd Sisters in Londonderry to take the children because they knew that the Good Shepherd Sisters looked after teenagers and unmarried mothers, and therefore that was the appropriate place to send children who had been exposed to some form of sexual behaviour. We also infer that because the practice of the Good Shepherd Sisters was not to refuse anyone they agreed to take HIA 107, GSC 16 and GSC 17. We consider this later.

123 In our opinion the only proper places for HIA 107 and the other two children to have been sent would have been childcare centred children's homes such as Coneywarren or Bishop Street. They should not have been sent to a place which was an adjunct of an adult establishment. The decision of the Juvenile Court is not within our Terms of Reference, and so we cannot characterise its order as amounting to systemic abuse within our Terms of Reference. Nevertheless, we must record our regret that the Juvenile Court thought it was appropriate to send at least one child who was a few days short of her twelfth birthday, and apparently two other children of approximately the same age, to a place where they would spend much of their upbringing in an environment dominated by large numbers of adult women working in an industrial laundry.

Education in the 1960s

124 HIA 107 says that she was put to work straight away in the sewing room and SR 49 remembers her working there. HIA 107 recalled that GSC 16 stayed in the sewing room, but she thought GSC 17's mother came for her at some stage and they then went to England.

125 HIA 107 said she was not sent to school, as she should have been as she was several years under the school-leaving age, which at that time was fifteen, and when she gave her evidence on Day 189, p.58 she was emphatic that she did not go to school after she arrived in the Good Shepherd in Londonderry. The March 1963 returns to which we earlier referred show that of ten girls under eighteen, two were fourteen or under[60]

60 GSC 5844.

and this would be consistent with HIA 107 and GSC 16 still being in the Good Shepherd at that time, when HIA 107 would have been fourteen.

126 The same returns list two girls in the column for girls aged five to fifteen as being at school full-time.[61] The returns also state that the complement of seventeen childcare staff in post "includes 3 teachers".[62] The equivalent entry for 31 March 1965 records three girls aged five to fifteen attending school "full-time", and notes that they "are educated within the precincts of the Home".[63] Although by March 1965 HIA 107 was no longer of compulsory school age, she was in March 1964, and it seems likely that she was one of the girls recorded as attending school in 1963 in the Good Shepherd. It therefore appears to be the case that HIA 107 did not leave the premises to go to a nearby school, but was taught in the Good Shepherd by extern teachers and by the Sisters themselves. That may be why she was mistaken in her recollection that she did not receive formal schooling while she was in the Good Shepherd in Londonderry.

127 HIA 387 spent five months in the Good Shepherd in Londonderry, arriving on 30 September 1963. She ran away from Londonderry to the Sisters in Belfast on 1 March, and moved to Newry on 2 March 1964. During the five months she spent in the Good Shepherd in Londonderry she was fourteen, and should have attended school because she was still of compulsory school age. The records for the period she was in Londonderry do not throw any light on whether she attended school during her five months there. The 1964 returns do not appear to have survived, but a handwritten Ministry of Home Affairs note covering the ten years from 1963 to 1973 simply records that in 1964 there were six girls under eighteen, none of whom were of school age.[64] As HIA 387 was under school age throughout her time in Londonderry that would suggest that if the 1964 figures are accurate, they were compiled after HIA 387 left Londonderry on 1 March 1964. That is quite possible, because both the 1963 and 1965 returns gave the figures at 31 March in each year.

128 HIA 211 was seventeen when she came to the Good Shepherd in Londonderry in June 1963, and as such was well over compulsory school age.

61 GSC 5847.
62 GSC 5840.
63 GSC 5828.
64 GSC 5327.

129 Such evidence as has survived, albeit limited, is consistent with girls under school-leaving age who were in the Good Shepherd in Londonderry in the early 1960s being taught on the premises, rather than going out to attend local schools. In the written submissions made on behalf of the Congregation following this module the Congregation said that it "regrets this failure to ensure that these three girls were not sent out to external schools".[65]

130 In our opinion it would have been much preferable for the children to have been sent to an external school because they would thereby have had the opportunity to interact with other children of their age, something that is an extremely important part of the process of adolescence. Nevertheless, we are satisfied that they were properly educated, and in those circumstances we do not consider that the failure of the children to attend external schools amounts to a systemic failing to provide proper childcare.

The Laundry in the 1960s

131 All three applicants who were in the Good Shepherd in Londonderry in the 1960s describe working in the laundry in some capacity. HIA 387's only memory of her time there is of working in the laundry. As she was of compulsory school age throughout her five months in Londonderry, and if she did attend school, she could only have worked in the laundry when she was not at school, such as during school holidays. The same would have applied to HIA 107 until she left school after ceasing to be of compulsory school age in November 1963. As she was sixteen when the Juvenile Court approved an application for her to be released into her brother's care in Germany, where he was serving with the British Army,[66] she would have worked full-time for about eighteen months before she left in February 1965. HIA 211 was seventeen when she arrived in June 1963 and she recalled working in the laundry during her time in Londonderry. As indicated earlier, she reached the age of eighteen three months after her arrival and so her experiences thereafter fall outside our Terms of Reference.

132 We accept that all three applicants worked in the laundry on occasions when they were under the age of eighteen. While HIA 211 was of an age when it would be appropriate for her to work in some capacity, such

65 GSC 24017.
66 GSC 3018.

as working in a laundry, we consider that it was wholly inappropriate for HIA 107 or HIA 387 to do so while they were still of school age, even at weekends or on school holidays. **We considered it was unacceptable for such young girls to be expected to do industrial work of this type even if the machinery had been recently modernised. This should not have been permitted by the Good Shepherd Sisters, and we considered this amounted to systemic abuse**.

Food in the 1960s

133 Of the three applicants who were in the Good Shepherd in Londonderry in the 1960s, only HIA 107 and HIA 211 referred to the food. HIA 107 referred to the food in her written statement as "slops", but when she gave evidence on Day 189, p.82, she said that was a bit of an exaggeration, but the food wasn't nice. She accepted that they never went hungry, whereas HIA 211 said in her statement that there was never enough food, and she was always hungry at breakfast. The Good Shepherd Sisters said that there was ample food which was simple and nutritious, and we are satisfied that there was no neglect in this respect.

Penances and the Black Book

134 HIA 107 and HIA 211 both recalled how any infringement of rules, or misdemeanours, were noted in a "Black Book", and at the weekend when the entire community was assembled together the entries in the Black Book were read out, and the offender had to kneel and apologise. The Good Shepherd Sisters accept that this was the practice from the 1950s until the mid-1970s when it was discontinued.[67] It is noteworthy that SR 49, who was in the Good Shepherd in Londonderry during these years, felt that the book "may wound a child's feelings",[68] and HIA 107 told the Inquiry that this was "a horrible thing to go through".[69]

135 Another form of punishment described by HIA 107 and HIA 211 was being made to eat a meal standing up; HIA 211 said that this could last for up to a week. SR 49 accepted that this may have happened, but said that it was generally only for one meal, and she felt that it was unlikely that it went on for a full week.

67 GSC 316-317.
68 GSC 317-318.
69 Day 189, p.80.

136 **We considered the practices of reading out misdemeanours in front of others and making the offender kneel, or making an offender stand to eat her meal, were a form of deliberate humiliation and amounted to emotional abuse.**

Silence at Meal Times

137 HIA 107 and HIA 211 recalled that there was silence at meal times, broken only by a nun reading. We have already described a similar practice in the Good Shepherd in Newry, and the Good Shepherd Sisters accept that it was the practice in Londonderry in the 1950s. We are satisfied that the same practice continued during the 1960s in Londonderry. Although we considered it was a poor and outdated practice, we did not feel that the adverse effect was sufficient to amount to systemic abuse.

Changing Names

138 As in the other Good Shepherd homes we have considered the Good Shepherd Sisters accept that names were changed on admission to the Good Shepherd in Londonderry in order to protect the privacy of the girls, so that others could not become aware of, or pry into, their background before they came to the Good Shepherd Sisters. As we have already explained this practice appears to have applied equally to women over eighteen and to girls under eighteen, and we understand may have been a widespread practice in mother and baby homes, although these are outside our terms of Reference. Although well-intended, this practice caused considerable distress and confusion to those affected. We considered that the practice continued longer in Londonderry than it should have done, and represented poor practice on the part of the Sisters.

Other Punishments

139 HIA 211 said that she was slapped on the face by nuns if she did not eat her meals, and that SR 47 who was the sister in charge of the girls, slapped her on the face for not being able to correctly identify the new decimal coins, and on another occasion because she did not know the words of a song. HIA 107 said that she was never physically abused by SR 47 and did not recall seeing a girl or lady being hit by any nun.[70] SR 49 accepted that SR 47 was "...quite strict. She was firm", but said that in

70 Day 189, p.72.

her time in St Mary's she did not see corporal punishment being inflicted on anyone.[71] Whilst we accept this may have happened, because only six months of HIA 211's time with the Good Shepherd Sisters in Londonderry comes within our Terms of Reference we cannot be satisfied that any such behaviour occurred during that six month period.

The 1970s

140 Two applicants describe their time in the Good Shepherd in Londonderry in the 1970s. HIA 202 came to Londonderry in January 1974 after her time in the Good Shepherd in Newry, which we have already described. She remained in Londonderry for fifteen months until she left in August 1975 when she reached the age of eighteen. As she was over sixteen when she arrived, she was over compulsory school age. She worked in the laundry for which she received pocket money.

141 It does not seem that she lived in Bellevue Hostel which opened in 1975, but whether she lived there or in the St Mary's accommodation, she described a much more relaxed atmosphere than that which appears to have existed in the early 1960s. She was allowed home on a number of occasions and she and other girls were allowed to go into town, although she was unsure whether they were actually encouraged to do so. She recalled one night when she and another girl went across the city into the Creggan Estate, and when she returned and was in bed SR 49 came in and struck her on the face.

142 She accepted that this was out of character for SR 49 and was a "one-off" incident, and she never saw anyone else slapped. At that time the Creggan Estate was one of the most dangerous places in Londonderry. It was the scene of rioting, explosions and numerous incidents where there were shootings at soldiers by terrorists and soldiers shooting at terrorists. There was therefore a grave risk of anyone in that area being caught up in a violent and potentially fatal incident. To get to the Creggan Estate from the Good Shepherd convent she had to cross from the Waterside area to the opposite bank of the river, and then make her way to the Creggan, a return journey of some miles.

143 It is not surprising that SR 49 was extremely upset and frightened by the danger to which HIA 211 had exposed herself by making this journey, and so over-reacted in a way which HIA 211 accepts was out of character. We

71 GSC 315.

accept this happened but do not consider that in these circumstances SR 49's behaviour amounted to systemic abuse.

144 HIA 7 was the only other applicant who was in the Good Shepherd in Londonderry. Her circumstances were somewhat unusual. Her mother arranged for her to be placed in the Good Shepherd for two short periods. The first was for five weeks from December 1976 until late January 1977, and the second was for three weeks in November 1978, by which time HIA 7 was sixteen.

145 HIA 7 says that before she was admitted to the Good Shepherd her mother took her to see the family GP and asked him to check HIA 7's virginity. The doctor was not appointed by, or acting at the request of, the Good Shepherd Sisters and we need not refer to this any further. As HIA 7 was only just fourteen when she was admitted on the first occasion she was still of compulsory school age, although two of the five weeks she spent at that time would have been the Christmas holidays. In her statement she said that she went to school while she was in the Good Shepherd.

146 In HIA 7's second period in the Good Shepherd in Londonderry she was only there for three weeks. She described how she worked in the laundry, and that some of the older women were bullies. She was allocated to work with SR 49 in the kitchen because she was being bullied, and says that it was SR 49 who arranged for her to be admitted to Coneywarren Children's Home in Omagh where she went at the end of her short stay in the Good Shepherd and where she was very happy.

Positive Accounts

147 HIA 7 recalled how a number of girls in the Good Shepherd told her that SR 49 had made positive changes to the place, and we have already referred to the improvements made to the living accommodation in the 1970s with the creation of the Bellevue Hostel. We should also record that we accept the evidence that from the mid to late 1960s onwards there were classes provided for all the women, including the children under eighteen who are within our Terms of Reference, in various skills such as typing and embroidery. SR 49 described music as a core part of life in St Mary's and girls were encouraged to take part in choirs and musicals. There was a recreation room with a TV, and in the summer there were holidays in Rathmullan, and later in Rossnowlagh, both in Co Donegal.

Admission of Young Children

148 The matter which troubled us most in relation to the Good Shepherd in Londonderry was the admission of very young children. While accepting that HIA 7 may have been a special case because she was only there for five weeks between December 1976 and January 1977, and that was perhaps understandable in view of the policy of the Good Shepherd Sisters of never turning anyone away, the same cannot be said for children such as HIA 107. HIA 107, GSC 16 and GSC 17 were very young when they were admitted in 1960, and the figures available would suggest that subsequently other children around fourteen years of age were admitted.

149 In its general submissions relating to all its homes the Congregation "accepts that having teenagers with adult women was not ideal", but they point out that efforts "were made within the existing facilities to make suitable safeguarding arrangements for those teenagers".[72]

150 We consider that an institution consisting predominantly of adult women working in a laundry was an entirely inappropriate place to bring up children as young as twelve. We recognise that in Londonderry HIA 107 (and it seems GSC 16 and GSC 17) were placed there under a court order, but we are in no doubt that the Good Shepherd Sisters should have refused to take the children on a permanent basis. **By accepting them on a long-term basis, which turned out to be over four years in the case of HIA 107, the Good Shepherd Sisters failed to ensure that proper care was provided for these children and that was a systemic failing on their part**.

Inspections

151 Although very few inspection reports of the Good Shepherd in Londonderry have survived, it is clear from occasional references in other documents that it was regularly inspected by inspectors from the Ministry of Home Affairs in the 1950s, 1960s and early 1970s. That was also the position for the Good Shepherd in Belfast and in Newry. Thereafter the responsibility for such inspections transferred to the SWAG (Social Work Advisory Group) of the DHSS. As we consider in greater detail in Chapter 2 (Finance and Governance) the SWAG did not carry out regular inspections of children's homes until at least the late 1970s, **and its failure to do so in relation**

72 GSC 24013.

to each of the three Good Shepherd Sisters Homes was a systemic failing.

152 Whilst no inspection reports of the Good Shepherd in Londonderry now exist for the early 1960s, we are satisfied that it was regularly inspected during that time. If there were inspections when HIA 107 and her companions, and other children under school leaving age, were living there, there is nothing to suggest that the inspectors expressed concern that such young children were living in an entirely unsuitable environment, or recommended that they be moved to a more suitable environment such as the Sisters of Nazareth in Bishop Street or a statutory home. In its response to the Inquiry Warning Letter the Department of Health argues that HIA 107 and her companions were deemed by a court not to be suitable for placement in a traditional children's home, and because the placement was in accordance with the contemporaneous advice of the Children's Welfare Council, there should not be a finding of systemic failing on the part of the Ministry of Home Affairs. We do not agree. Notwithstanding that a court order had been made, by the 1960s it should have been appreciated by all concerned, especially the inspectors, that it was completely unacceptable to place children under school leaving age in an institution of this type. These children should not have been there. If the inspectors did not detect this they failed in their duty to properly inspect. If they were aware and did not take any steps to try to get the order changed, they were equally at fault.

Administering Authority

153 There was also a failure for many years to appreciate that the Good Shepherd Sisters was the administering authority for each of the three homes, and as such obliged to put in place a system of monthly visitors as required by the Voluntary Home's Regulations. It appears that it was a SWAG inspection of Marianville in Belfast in 1984 that first brought the absence of such a system to light,[73] after which the position was rectified and a system of monthly visitors put in place.[74] **The absence of such a system is a systemic failing by the Good Shepherd Sisters. The failure to detect that absence was a systemic failing on the part of the Ministry of Home Affairs and the Social Work Advisory Group.**

73 GSC 6408.
74 GSC 6434.

Apology by the Good Shepherd Sisters

154 In her evidence on behalf of the Congregation on Day 194, Sr Ethna said:

> "...we all would like to communicate to the Panel and the Inquiry that we welcome this Inquiry. We appreciate -- we appreciate it is important for all voices to be heard and we regret that some of our former residents have painful memories of the time spent in our care. Our Sisters have maintained contact with some of the applicants and many other former residents over the years, and we remain open to engaging with former residents in a pastoral context, and we hope that through our cooperation with the Inquiry and through any future pastoral outreach to former residents, who have painful memories of time spent in the care of Good Shepherd, that they may find healing."

Conclusion

155 We have concluded that there were the following systemic failings on the part of The Congregation of the Good Shepherd Sisters.

- **It was unacceptable for young girls under the age of eighteen to be expected to do industrial work in the Good Shepherd laundries.**
- **Permitting girls to be asked by a priest whether each was a virgin.**
- **The practices of reading out misdemeanours in front of others and making the offender kneel, or making an offender stand to eat her meal.**
- **By accepting children under school-leaving age, such as HIA 107 and her companions, into one Good Shepherd institution that was not completely child-centred in the way that other Good Shepherd institutions were designed to be on a long-term basis the Good Shepherd Sisters failed to ensure that proper care was provided for these children.**
- **The failure of SWAG to carry out inspections of each of the three Good Shepherd Sisters Homes was a systemic failing.**
- **The failure of each of the three Good Shepherd Sisters Homes to put in place a system of monthly visitors was a systemic failing.**

156 Systemic failings by the Ministry of Home Affairs.

- **Failing to take steps to prevent children under school-leaving age, such as HIA 107 and her companions, being in the Good Shepherd on a long-term basis.**

157 Systemic failings on the part of the Ministry of Home Affairs and/or the DHSS.

- **Failing to detect the absence of a system of monthly visitors was a systemic failing on the part of the Ministry of Home Affairs and the Social Work Advisory Group.**

Chapter 22: Contents

Module 15 – Bawnmore Boys' Home

Introduction

1 Although Bawnmore Boys' Home was examined as part of Module 15 of the Inquiry because a number of those who were resident there were later moved to Kincora Boys' Hostel, we consider that Bawnmore should be dealt with in a separate chapter of our Report. Bawnmore is not to be confused with another children's home of the same name in South Belfast. The Bawnmore in this chapter was the home at Mill Road, Newtownabbey, Co Antrim, which existed between 1952 and 1977.

2 The evidence relating to Bawnmore was considered on days 208, 209 and 210, during which we heard evidence in person from four applicants: HIA 112, HIA 532, HIA 199 and HIA 409. We considered the evidence of HIA 83 who gave evidence at an earlier stage of the Inquiry, and we considered it unnecessary to ask him to give evidence again. We also received evidence from two former members of staff: BM 4 gave evidence in person, whilst BM 13 provided the Inquiry with a written statement.

3 We received a witness statement from Fionnuala McAndrew on behalf of the Health and Social Care Board, as the successor to the Belfast Welfare Authority and the Northern Health and Social Services Board (NHSSB), which took over Bawnmore with the reorganisation of local government in 1973 and ran it until it closed in 1977. We also received a witness statement from Dr Hilary Harrison on behalf of what was at that time the Department of Health and Social Services and Public Safety (DHSSPS) and is now the Department of Health, and from Richard Pengelly, who is Permanent Secretary of the same department.

4 Bawnmore was one of the homes investigated by the Hughes Inquiry because of offences involving the abuse of children at the home. They came to light during the wider Caskey Phase One investigation by the RUC, which had been set up following the publication of the article in the Irish Independent of 24 January 1980 to which we refer in greater detail in the chapters relating to Kincora. The Caskey Phase One investigation was not simply confined to Kincora; it covered a number of children's homes or hostels, including Bawnmore. As a result of that investigation the police uncovered allegations against five men, two of whom (Peter Bone and Robert Elder) were prosecuted, pleaded guilty and were sentenced by Lord Lowry, Lord Chief Justice, on 16 December 1981 for offences relating to Bawnmore, at the same time that Mains, Semple and McGrath were sentenced for offences related to Kincora, and Eric Witchell was sentenced for offences relating to Williamson House.

Bawnmore and its origins

5 Bawnmore House was situated on the Mill Road on the outskirts of North Belfast. As was the case for a number of the institutions we examined during this Inquiry, it had been a large private family residence. It became a children's home as the result of an initiative by the then Board of Guardians of the Belfast Union to provide accommodation for children who had been living in the workhouse. The property was purchased in 1948 and transferred to Belfast Corporation. After the Children and Young Persons Act (Northern Ireland) 1950 became law the Belfast Welfare Authority opened it as a children's home in May 1952.

6 For some years the home accommodated both boys and girls, and as late as August 1959 five girls were still resident. In due course it became solely a boys' home, although there was a plan which was never implemented to re-admit girls in the 1970s. No girls came forward to our Inquiry to complain about their time in Bawnmore. This chapter therefore deals only with allegations made by boys, and so we refer to it by the name it bore for much of its existence, Bawnmore Boys' Home.

The buildings

7 Bawnmore was a large building. Plans from the time it was purchased show a drawing room, dining room, billiard room, morning room and cloakroom on the ground floor. On the second floor there was a ballroom and bedrooms. In the attic there were rooms used as apartments by the maids. As well as an internal courtyard, there were garages, an open yard and stables. It was set in extensive grounds, and in later years a football pitch was laid out.

Numbers

8 Although the home had accommodation for 28 to 30 children, in the late 1960s and during the 1970s overcrowding was a recurring problem. In June 1969 there were 31 boys in residence.[1] By September of that year the number had increased to 33,[2] although by the end of October 1969 the number had been reduced to 29.[3] By April 1971 the number of boys had risen to 32.[4]

1 BWN 7676.
2 BWN 7682.
3 BWN 7683.
4 BWN 7707.

9 During this period the Belfast Welfare Authority recognised that conditions in the home were unsatisfactory. In August 1969 it was noted that:

> "It is becoming increasingly apparent that the facilities at Bawnmore are not adequate for the number of boys cared for there and it would seem that consideration must also be given to increasing the staff in order to allow for more individual attention to be given."[5]

10 In September 1969, when there were 33 boys, it was accepted that despite the home being fully staffed, "it is probable that the staff/children ratio is too low".[6] In October, the number of boys had reduced to 29, and efforts were being made to retain this level of occupancy, even though it meant refusing to admit children to care. In his report on the home to the Welfare Committee the Children's Officer pointed out that there was a vacant post of housemother's assistant, and the remaining staff were finding it extremely difficult to afford each boy the individual attention which he required.[7] The difficulty experienced in filling the vacant post was similar to that experienced when filling vacancies at Kincora which we examine elsewhere in this Report. At this time local authorities throughout the United Kingdom found it hard to recruit suitable staff for such posts because the posts were residential, demanding, poorly paid and involved long hours.

11 In November 1969 the Welfare Committee decided a new home to accommodate 36 boys should be built on the Bawnmore site.[8] However, by 1971 the necessary plans had not been prepared because of the pressure of other work in the City Architect's Office.[9] The plan to build a new building does not appear to have proceeded any further.

12 By this time such large institutions were completely out of date, and we find it surprising that it was thought appropriate to consider building a new institution of this size. This is particularly the case because in 1955 the Belfast Welfare Authority put forward a plan to build cottages on the site to provide family group homes. This was not favoured by the Ministry of Home Affairs, which preferred the establishment of family group homes, or Family Unit Homes as they were called, in ordinary dwelling houses scattered throughout the residential areas of the city. The Minister

5 BWN 7678.
6 BWN 7682.
7 BWN 7683.
8 BWN 7688.
9 BWN 7709.

reluctantly agreed to withdraw the Ministry's objection to the scheme if the cost could be significantly reduced because it had gone so far.[10] However, it proved impossible to reduce the cost to acceptable levels, and in 1957 the Minister refused to approve the plan because it was too expensive, and expressed the hope that "family-group homes, if needed, will in due course emerge in the various City residential areas."[11]

13 By the time the 1969 proposal was put forward, Belfast Welfare Authority had seven group homes in various areas, which makes it even more surprising that such a proposal was put forward at all. In any event, the proposal never came to fruition, whether it was recognised to be undesirable in principle, or because of the imminent reorganisation of local government.

14 A *Review of Bawnmore Boys Home* was prepared by the NHSSB in April 1984, evidently for the Hughes Inquiry. This described how Bawnmore left a great deal to be desired as a children's home when it was taken over by the NHSSB on 1 October 1973 as a consequence of the reorganisation of local government and the health and social services which resulted in the creation of four regional health and social services boards. It identified three major deficiencies: the records were incomplete; some 75% of the staff, including the superintendent and deputy, had chosen to transfer to the Eastern Board; and, finally, the building was in a poor physical condition, and a high level of vandalism "and an almost self destructive behaviour" existed among the boys, resulting in widespread damage to the furniture, decor and fabric of the building.[12]

15 Almost immediately, planning began for a replacement of Bawnmore. In the interim, steps were taken to introduce a group living system, and by February 1976 the necessary structural alterations had been carried out, and the group system was said to "have settled down and was beginning to produce benefits in standards of child care."[13]

16 Unfortunately, the location of the home and its extensive grounds brought additional problems. The grounds were used as a public park, and there were clashes, mainly of a sectarian nature, between locals and children and staff from the home. By 1976 the situation had deteriorated to such an extent that staff were frightened and childcare practice affected, and

10 BWN 5583.
11 BWN 5559.
12 BWN 5705.
13 BWN 5708.

the author of the *Report re Situation at Bawnmore Children's Home* recommended that the Board find alternative accommodation for the home.[14] In October 1976 a decision was made to close the home, and new premises were purchased at Coulter's Hill, Ballyclare. The children and staff were transferred to Coulter's Hill, and Bawnmore officially closed on 30 March 1977.[15]

Staffing

17 The problem with staffing in 1969 that has already been referred to was not new. A note made by the MoHA in December 1965 following an inspection referred to;

> "Shortage of staff, high numbers [of residents], delays in providing adequate heating/decoration suggests that this home is not getting enough priority in Belfast...Staff shortage in particular seems to need positive action."[16]

18 Staff shortages seem to have been a recurring problem from time to time during Bawnmore's existence. In 1955 there was a reference to the strain placed on the matron who had almost no time off because her assistant had left and not been replaced.[17] In 1967[18] and 1968[19] there are references in MoHA inspection reports to vacant posts. This meant that some staff were required to work for long periods of time without any time off.

19 BM 4 worked at Bawnmore for almost two and a half years between 1963 and 1965, and again for almost a year from February 1968.[20] He told the Inquiry that he once had to work constantly for three months without a break because of the lack of staff,[21] although he did not say in which of his two periods of employment that occurred. This experience echoed that of Joseph Mains at Kincora, who worked for very long periods of time without any staff to help him as we point out in that part of our Report relating to Kincora.

14 BWN 5700.
15 BWN 5710.
16 BWN 5724.
17 BWN 5754.
18 BWN 5752.
19 BWN 5751.
20 BWN 26574.
21 Day 209, p.8.

20 The Belfast Welfare Authority faced recurrent staffing problems, which indicates that insufficient resources were being provided to improve staffing in Bawnmore. Although the MoHA were told in December 1965 that it was hoped "to authorise more attractive salary scales",[22] staffing problems continued to be noted in 1969, which suggests that more needed to be done to try and resolve this problem.

Absconding

21 Absconding appears to have become a major problem in October 1974, with almost 50% of the boys absconding at that time. It would appear from the *Review of Bawnmore Boys Home* to which we have already referred, that at least four members of staff, and the new superintendent, were felt to have, "very rigid and inflexible approaches to care".[23] The implication was that these members of staff were not satisfactory, and this may have contributed to the high level of absconding. It is noteworthy that later in the *Review* the author refers to a number of those named as having departed during 1975, saying this meant there was a considerable period of major staff instability.[24]

22 The absence of reports from the Social Work Advisory Group (SWAG) of the DHSS for the period from 1973 until Bawnmore closed in March 1977 means that there is no further information about the rate of absconding, although it is perhaps fair to surmise from the absence of further references to it in the reports to which we have referred that the problem diminished. However, that it reached almost 50% at one point indicates that at that time insufficient, or inadequate, efforts had been made to address the causes of absconding. Absconding at this level suggests that, in part at least, it was due to failings on the part of a number of members of the staff at that time, because earlier reports from the MoHA do not contain references to significant levels of absconding from Bawnmore, and so there is no evidence that absconding was a problem in earlier years.

Conditions in Bawnmore

23 Of the four applicants who had been in Bawnmore and who spoke to the Inquiry, HIA 199 and HIA 409 had no complaints about their time there. HIA 199 was at Bawnmore when there were still girls in the home, and

22 BWN 5728.
23 BWN 5708.
24 BWN 5709

remembered trips to the seaside. Although there are references to poor heating in the home, and to the need for redecoration in the mid and late 1960s, none of the applicants complained of being affected by such problems to a degree that would amount to neglect. Facilities for recreation included the construction of a football pitch in 1965.[25] Recreational activities in the 1960s were provided with the help of volunteers who helped with Scouts, cookery, woodwork and drama.[26] At one stage a magazine was produced, although this lapsed, at least for a while, due to staffing problems.[27] Other activities, such as trips to a nearby swimming pool, were recorded by inspectors.

24 Considerable efforts appear to have been made by BM 3, who was the Superintendent at the time, to ensure that a wide range of activities were available to the children in the 1960s and early 1970s. Whilst the staffing difficulties to which we have referred raised concerns from time to time about the ability of staff to devote enough time to the children, overall the amount of attention given to the children appears to have been satisfactory.

Bullying

25 HIA 112 was in Bawnmore from May 1966, although it is not possible to establish how long he was there as no records had been found relating to him. He told the Inquiry that although he was bullied by older boys, who took a pair of jeans from him that had been given to him by his mother, and some older boys beat up younger boys, he did not regard it as really serious, seeing it as just the kind of boisterous behaviour engaged in by older boys.[28] He said that the staff turned a blind eye unless there was a particularly serious fight when they would intervene.

26 HIA 83 was in Bawnmore from mid-December 1976, and then moved to Coulter's Hill for a short time after Bawnmore closed at the end of March 1977. In his statement, HIA 83 described being bullied by three brothers in both Bawnmore and Coulter's Hill, and as a result said he started to run away and truant from school. He claimed that he told BM 13 a member of staff, who did nothing about it. BM 13 made a statement to the Inquiry in which he said that he had no recall of being told this, although he

25 BWN 5719.
26 BWN 5721.
27 BWN 5718.
28 Day 208, pp. 81 and 82.

accepted that HIA 83 was one of the children staff identified as vulnerable and prone to being bullied. He said he had no difficulty in accepting that HIA 83 had been bullied, adding;

> "...it is also the case that this was an endemic problem within that environment affecting many children and is something that as a staff group we were fully aware of and did our best to manage."[29]

27 Bullying can be a risk in any children's home. Staff have to be alert to that risk, and take suitable steps to prevent it wherever possible. As only two individuals have alleged that they were bullied, we consider that this is insufficient to the level of widespread bullying that would amount to systemic abuse.

Physical and Emotional Abuse

28 HIA 112 alleged that he was called a "dirty wee taig" by BM 3 – the Superintendent – and by BM 4 – the Assistant Superintendent. BM 3 is dead and BM 4 denied doing so. HIA 112 was a Roman Catholic in a home that was predominantly composed of Protestant boys during his time. Using such terms, particularly by staff, would be wholly unacceptable. HIA 112 also alleged that when he wet his bed BM 4 rubbed his face in the wet sheet, spat on his face, stripped him naked and put him in a cold bath. BM 4 denied each of these allegations, and pointed to his efforts to reduce the prevalence of bed wetting during his time at Bawnmore. He explained that children with enuresis were referred to hospital, and a programme was then put in place in the home to help the children concerned. As a result, at one stage where there had been 24 children bed wetting the number was reduced to 4. While we accepted HIA 112's account of his experiences, we are satisfied they were an isolated series of events, and do not amount to a systemic failing. We accept that the methods described for dealing with bed wetting were appropriate.

Sexual abuse

29 As we have explained, Bawnmore was one of the homes investigated by the RUC during the Caskey Phase One investigation. The police were provided with files relating to 135 boys dating back to 1963, although this was only a small proportion of the total number of residents who had

29 BWN 35035.

passed through the home.[30] Although not all the boys on the list could be traced, the police investigation identified eleven former residents who between them made allegations of sexual abuse by five men. Two of these, Peter Bone and Robert Elder, were subsequently convicted.

30 A third person, S 2, was traced by the RUC to Canada and was interviewed by them in 1982. At that time he denied any offences. In 1985 S 2 visited Northern Ireland on holiday, and was again questioned by the RUC. On that occasion he admitted masturbating HIA 532. He also admitted similar activity in Firmount Children's Home in Antrim. The DPP directed no prosecution, pointing out that the only criminal offence that could be established in relation to HIA 532 was one of indecent assault. As the offences occurred seventeen years before, it was considered that the passage of time rendered proceedings stale and inappropriate.[31] Shortly after S 2 returned to Canada in 1985 he wrote to the RUC admitting masturbating another juvenile at Conway House Children's Home. The RUC decided not to refer the letter to the DPP, no doubt mindful of the DPP's earlier decision. Allegations of abuse were also made against two other former staff members, S 1 and BM 1.

31 Peter Bone was a married man with grown-up children and worked as an architect employed by the North Eastern Education and Library Board. He was prominent in the Scout movement, and another interest was photography. His initial involvement with Bawnmore came about when he went there to study arrangements for social service. He later returned to Bawnmore as a volunteer to help staff with activities. Over a period of several years he took HIA 532 on numerous trips in his car, including some visits to Bone's home. Bone admitted sexually abusing HIA 532, and to taking nude photographs of him and other boys. A search of his home discovered photographs of other naked boys who had not been resident at Bawnmore. Three of those boys who were traced by the police alleged that Bone had sexually assaulted them. On 16 December 1981 at Belfast Crown Court he was sentenced to a total of two years imprisonment on eight charges of gross indecency and eight charges of indecent assault.[32]

32 Although the offences against HIA 532 were committed outside Bawnmore, they are relevant to our Inquiry because the opportunity for Bone to commit

30 BWN 20014.
31 BWN 20199.
32 BWN 20665.

these offences came about when he was permitted to take HIA 532 out of the home. At that time there were no formal instructions in place for members of the public to be vetted who wished to take children out from time to time, although there was a formal vetting procedure for individuals who wished to befriend a child in care on a more continuous basis. The level of contact between Bone and HIA 532 was very substantial and lasted for a considerable period of time. We consider that formal vetting of Bone should have taken place, and **the failure to vet him amounted to a systemic failing by the Belfast Welfare Authority**.

33 However, we recognise that such vetting would not have revealed his predilections for sexual abuse of children. To all outward appearances at the time he was a respectable person. He had no previous convictions, was married with children, and employed in a responsible position by a public authority. He was also prominent in the Scout movement, something that suggested he had a genuine interest in youth work. HIA 532 said he did not reveal Bone's behaviour to the Superintendent BM 3, to his social workers or to his parents as "I was embarrassed to even think of it and just could not face actually telling anyone."[33] In the absence of a complaint it is difficult to see how Bone's behaviour could have been discovered or prevented by any form of vetting procedure at that time.

34 However, although HIA 532 did not tell anyone about the abuse at the time, he told us that after he left Bawnmore he told BM 1 about it. BM 1 had been employed as a house-master in Bawnmore from December 1965 until 1975 when he moved to work in the Palmerston Assessment Centre. HIA 532 told us that he visited BM 1 at Palmerston and told him about the abuse. He recalled that BM 1 told him he had a vague recollection that he suspected something was going on because Bone was persistently buying HIA 532 things.[34] In his response to the Inquiry Warning Letter BM 1 denied that he was told of allegations of abuse at Bawnmore while working at Palmerston, or that he was aware of concerns about Bone from HIA 532 or anyone else.

35 This suggested that if staff in Bawnmore had been more questioning about the extent and nature of Bone's relationship with HIA 532 that could have served, at least, to put Bone on notice that his contact with the boy was being monitored which might have prevented some of the abuse. Although

33 KIN 021.
34 KIN 021.

HIA 532 was no longer in care when he told BM 1 about the abuse, BM 1 was employed by the Eastern Health and Social Services Board and it would still have been appropriate for BM 1 to report the abuse to his seniors and for them to have reported Bone to the police. As we consider later, BM 1 was himself subsequently convicted of indecent assault of boys in Palmerston and it may be that his decision not to report Bone's abuse of HIA 532 was in order to avoid a more widespread investigation. Whatever the reason, **we consider his failure to report the abuse amounted to a systemic failing**.

36 HIA 532 was also abused by S 2, the Assistant Superintendent. Although S 2 initially denied the allegations, he later admitted masturbating HIA 532 on one occasion when HIA 532 stayed overnight at S 2's parents' home in 1968 as HIA 532 alleged.[35] However, S 2 denied that he rubbed HIA 532's penis through his trousers whilst the boy was lying on his bed after he had been to hospital to have stitches removed from a cut to his hand.[36] Again HIA 532 explained why he did not report what had been done to him by S 2 when he said:

> "I did not tell [BM 3] about [S 2] abusing me in my room, nor about Peter Bone. I think this was because I was young and I did not really know that what they were doing was abuse and was wrong. I just thought it was part of growing up."[37]

37 HIA 532's explanation was perfectly understandable. However, he was also sexually abused by Robert Elder whilst Elder was on a short term student placement at Bawnmore. HIA 532 made two distinct allegations against Elder. The first was that when HIA 532 was about ten, Elder took him from his room at night to the room where Elder slept when he was on night duty, masturbated him and performed oral sex on him. HIA 532 also alleged that Elder tried to make him perform oral sex.

38 The second allegation related to the day when S 2 touched him sexually while HIA 532 was lying on his bed. He said that Elder came to his room and showed him pornographic photographs of young boys and girls, and told him to keep them. However, a few minutes later Elder returned and retrieved the pictures, telling HIA 532 not to tell anyone what happened, and threatening to involve him in the activities depicted in the photos.

35 KIN 023.
36 KIN 021.
37 KIN 022.

HIA 532 said he was terrified by this because the photographs showed bottles being inserted into the children.

39 He told an older boy about this later the same day, and that night the boy brought HIA 532 to see the Superintendent in his bungalow, which was on the site. HIA 532 said to the police that he told BM 3:

> "...what this man was doing to me. He asked me to try and get one of the photographs as proof as there was little he could do without something to go on."[38]

BM 3 told the police that HIA 532 only complained to him about Elder showing him "dirty photographs". BM 3 said:

> "I spoke to Elder and he admitted having these photographs and I told him not to have them in the house as they were not proper things for young boys to see."[39]

40 BM 3 told the Hughes Inquiry that HIA 532 did not speak to him about anything other than the photographs. At first sight that may seem plausible, because HIA 532 had said he did not mention the abuse to anyone. When he described these events in his evidence to the Inquiry on Day 208 at p.121 he was unsure whether he told BM 3 about the abuse as well as about the photographs. However, Elder admitted to the police that BM 3 spoke to him about what HIA 532 had said.

> "I remember [HIA 532] told [BM 3] the Head of the Home about what had happened. [BM 3] approached me about this and I denied it. [BM 3] obviously believed me and all he told me was not to become too friendly with any of the kids."[40]

41 The Hughes Inquiry considered the apparent conflict between these accounts and concluded at 6.38 of its Report:

> "On balance, however, we believe the evidence is that a complaint about Mr Elder's homosexual activities was made and that [BM 3] was deceived by a denial and a story about the photographs which he should at least have sought to check by insisting on their production."[41]

The reference to a "story about the photographs" refers to BM 3's evidence to the Hughes Inquiry that he was told the photographs were of "famine stricken countries showing native people partially dressed."[42]

38 KIN 20041.
39 BWN 20070.
40 BWN 20091 and 20092.
41 BWN 25168.
42 BWN 25167.

42 In view of Elder's admission to the police that BM 3 spoke to him about the sexual abuse, we are satisfied that BM 3 was told about that, and not just told about the photographs.

43 We consider **there were a number of systemic failings in the way this matter was dealt with:**

- **No written record was made of the allegations, or of Elder's response, by BM 3.**
- **BM 3 did not investigate the allegation about the photographs by asking to see them as he should have done.**
- **BM 3 did not report the matter to his superiors as he ought to have done**.

44 HIA 532 connected these events to having stitches removed from his hands in February 1968.[43] If he were correct that these events happened in February 1968 that is significant, because that would place it after the investigation by Mr Mason into the 1967 allegations at Kincora. In the chapter dealing with Kincora we say that Mr Mason should have issued instructions to all the homes run by the Belfast Welfare Authority that any such allegations should be reported to him. Had such procedures been in place at that time then that should have resulted in the matter being investigated, and possibly that would have led to it being referred to the police. These events involving Elder at Bawnmore are a further illustration of the consequences of there not being such a procedure, and as a result senior staff were being kept in ignorance of serious allegations by the failure of staff at a lower level to report such matters.

45 Elder was also prosecuted and pleaded guilty at Belfast Crown Court to two counts relating to HIA 532, one of indecent assault and one of gross indecency. On 16 December 1981 he was sentenced to one year's imprisonment suspended for two years on both counts.

46 S 1 spent two periods working in Bawnmore as an assistant house-father. The first was from mid-January 1963 until the end of May 1965. The second was from February 1968 until February 1969. During the Caskey Phase One investigation four former Bawnmore residents made allegations against him, ranging from attempts to kiss them, to several allegations of alleged anal penetration. He resigned in 1969. By 1982 he had emigrated to Canada, where he was questioned by Detective Superintendent Caskey

43 KIN 021.

and Detective Sergeant Elliott. He denied all of the allegations. In 2012 another former resident of Bawnmore came forward to Manchester police and alleged that S 1 liked to rub himself against the boys, and always had an erection.

47 In 1980 BM 20 complained that when he was smacked by BM 1 with his hand, the hand would remain on his bottom between smacks. BM 1 denied these allegations and the DPP directed no prosecution.

48 In January 1982 BM 1 was suspended following complaints to the police during the Caskey Phase Two investigation. He admitted that he had left his hand on children's bottoms for longer than was necessary after smacking them. Some of the boys had been clothed, others were unclothed. He denied allegations that he touched some of these boys on the penis.

49 BM 1 was prosecuted in the Magistrates Court on nine charges of indecent assault in respect of the offences at Palmerston. He pleaded guilty, and was given an absolute discharge. In 1992 he was acquitted of charges of indecent assault on a boy Scout.

50 We are satisfied that several boys were sexually abused by staff members while living in Bawnmore, and those abused included HIA 532 who was abused by Bone, a regular visitor to Bawnmore. **The number of offences amounted to systemic abuse**.

51 We have given considerable thought as to how it was that there were a number of sexual abusers of children connected with Bawnmore. We have found nothing to suggest a pattern that would suggest that such abusers were knowingly recruited to Bawnmore. We consider that the sexual abuse to which we have referred was able to take place because the abusers were able to exploit a culture of lax supervision of staff by the superintendent.

Records, monitoring and inspection

52 The Hughes Inquiry examined the relevant records from 1963 to 1973 and concluded that there was almost complete compliance with the statutory obligation on the Children's Officer to visit the home every month. Although the reports were described as tending to be short and stereotyped, from time to time they contained references to the condition of the home, truanting and absconding. However, the absence of records relating to Bawnmore prevented us, as it did the Hughes Inquiry, from establishing what action, if any, was taken to deal with such problems.

53 Although the absence of some records may be attributed to the inevitable disruption caused by the transfer of the home from the Belfast Welfare Authority to the new Northern Board in 1973, and to the rapid closure of the home in March 1977 when residents and staff moved to Coulter's Hill, that may not be the whole story. The *Review of Bawnmore* referred to records being incomplete when the NHSSB took over responsibility for Bawnmore on 1 October 1973. When the police carried out their investigations in 1980 they found that the admission's register had gone astray. These deficiencies suggest that record keeping at Bawnmore may have left something to be desired, but the absence of records makes it difficult for us to establish to what extent that may have been the case.

54 The Hughes Inquiry noted that whilst members of the Welfare Committee visited regularly between 1960 and 1965, there were frequent gaps in such visits in 1967 and 1968, followed by a significant further decline from 1971 onwards.[44] We agree with the Hughes Inquiry that it was unsatisfactory that the Welfare Committee neglected its statutory duty to visit, and **we regard its failure to fulfil that duty as a systemic failing**.

Departmental inspections

55 Until the childcare function of the Ministry of Home Affairs was taken over by DHSS in 1973 such records as had survived satisfy us that there were regular visits by MoHA inspectors. Some reports by Miss Hill and Miss Forrest have survived. Records from other homes show that the Ministry inspectors were regular and conscientious in their inspections, and we see no reason to conclude that regular inspections at Bawnmore did not take place when that was the responsibility of the MoHA.

56 There are no records of any formal SWAG inspections of Bawnmore being carried out between 1973 and 1977. Although the Department's response to the Warning Letter sent to it by the Inquiry points to evidence that there were some inspections of other statutory homes during this period, the routine destruction of inspection records makes it difficult to establish which homes were inspected and which were not. However, Mr Armstrong confirmed to the Hughes Inquiry that at that time the emphasis of SWAG was on inspecting voluntary homes. We are satisfied that because some homes were inspected it cannot be assumed that Bawnmore was also inspected. Elsewhere in our report we explain why we

44 BWN 25165.

consider the absence of such inspections by SWAG was unjustified, and we consider **that the failure to ensure that inspections of Bawnmore were carried out by SWAG between 1973 and 1977 was a systemic failing by the DHSS.**

Findings of systemic failings

57 **The failure to vet Peter Bone amounted to a systemic failing by the Belfast Welfare Authority.**

58 **The failure of BM 1 to report the abuse of HIA 532 by Bone to his seniors.**

59 **In relation to the allegations made against Elder by HIA 532 to BM 3.**

- **BM 3 did not make a written record of the allegations, or of Elder's response.**
- **BM 3 did not investigate the allegation about the photographs made by HIA 532 against Elder by asking to see them as he should have done.**
- **BM 3 did not report the matter to his superiors as he ought to have done.**

60 **A number of boys were subjected to sexual abuse by staff members.**

61 **The Welfare Committee neglected its statutory duty to visit the home.**

62 **The failure by SWAG to carry out inspections.**

Chapter 23:

Module 5 – Fort James Children's Home and Harberton House Assessment Centre

Introduction

1 The Inquiry devoted Module 5 to the examination of particular aspects of the operation of two children's homes in Londonderry: Fort James and Harberton House. Both these homes were managed by the Western Health and Social Services Board (WHSSB), now succeeded by the Western Health and Social Care Trust (WHSCT). Our focused consideration of these homes was prompted by evidence we received from former residents and by police material about investigations they carried out in relation to the homes.

2 Two former residents of Fort James, HIA 108 and HIA 60, and one former resident of Harberton House, HIA 233, raised issues about the care they received in these homes as part of the evidence they gave during Module 1 of the Inquiry, which considered children's homes run by the Sisters of Nazareth in Londonderry.

3 The material we received from the police concerned their investigations into an allegation that FJ 5, the officer in charge of Fort James from September 1980 to August 1983, sexually abused a male resident in the home and into incidents of peer sexual abuse in Harberton House in 1989-1990, 1992 and 1994.

4 The Inquiry devoted eight sitting days spread over two weeks to this module, commencing on 8 June 2015 and finishing on 18 June 2015. HIA 108's evidence about her time in Fort James in 1980 and HIA 233's evidence about her time in Harberton House in 1991-1992, and responses to their evidence, were heard in Module 1. Therefore, HIA 108 and HIA 233 were not required to go through the pressure of giving evidence in person again in Module 5. Transcripts of relevant parts of the evidence they gave in person in Module 1, and responses to it, were considered during Module 5. HIA 60's evidence about his time in Fort James in 1980-1981 was not heard when he gave evidence in person in Module 1 and therefore he did attend and gave evidence during Module 5.

5 In addition to the evidence from these former residents, we heard evidence from staff who worked in the homes, HH 5, FJ 33, HH 22 and FJ 7, and from senior managers responsible for the operation of the homes, Dominic Burke and Gabriel Carey. Dr Kevin McCoy, Denis O'Brien and Marion Reynolds gave evidence about the inspection and regulation of the homes and Dr Hilary Harrison gave evidence on behalf of the Department of Health, Social Services and Public Safety (DHSSPS).[1]

1 FJH 60077-60081.

6 We also considered written statements from previous senior WHSSB managers such as Thomas Frawley, who was the Area General Manager of the WHSSB from 1984 to 1995[2], and from the current Director of Women and Children's Services and Executive Director of Social Work of the WHSCT, Kieran Downey.[3]

7 We are grateful for all the evidence we received, which assisted our understanding of the development and operation of these homes within the wider childcare services provided by the WHSSB.

2 FJH 599-770.
3 FJH 771-791 and 838 -859.

Part One:

Fort James Children's Home

8 Fort James children's home opened in 1973 and accommodated children from the Londonderry, Limavady and Strabane district (later Unit), until it closed on 31 March 1995. The home was originally built as a private residence in 1862, and was set in wooded grounds in Ardmore Road around three miles from the centre of Londonderry. It was a three-storey property with additional outbuildings at the rear. When it opened in 1973 it was located between two Housing Executive estates, Tullyally and Currynierin.

9 The Health and Social Care Board (HSCB) explained in its submission to the Inquiry that only limited records are available in relation to the early years of operation of Fort James. The available records show that the majority of children accommodated in the home between 1973 and 1978 were babies and young children up to the age of five, although one or two older teenagers were also accommodated in the home during this period. Initially the senior staff member of the home was called matron and the other staff were called nursery nurses.

10 HH 22 commenced work in Fort James in 1975 and by that time the title houseparent was being used for staff. HH 22 was appointed to the post of senior house parent. She told us that when she commenced work in the home there was a nursery on the ground floor with cots for three babies and that the oldest resident was seventeen-years-old. She explained that the staff received little information about the circumstances that led to children being admitted to the home and that although the practical needs of the children were met there was little therapy or care planning provided. She commented, "it was all about group living, with little opportunity for individual time, because of the small staff team and wide age range", and that it was "very difficult to observe or monitor the children's whereabouts both in the badly laid out house and the large grounds".[4]

11 The HSCB informed us that in and around 1978 the nursery in the home was closed and the intention was to develop a home for older children. When Harberton House opened in 1980, Fort James' remit was confirmed as being specifically to provide medium or long-term care for sixteen children, aged between five and seventeen years. The stated aim of the

4 FJH 40182.

home was to assist children to return to their parents, prepare for a foster placement, or prepare for independent living in the community.

12 Given the focused nature of our consideration of Fort James it would not be appropriate to consider the governance, funding and operational arrangements in detail. However, it was clear from the evidence of previous staff and managers of Fort James and contemporaneous documentation that the home faced significant challenges in meeting its stated remit. This was, due in the main, to the number of emergency placements it had to accommodate, which included the placement of younger children with a range of needs. Emergency placements also led at times to a high throughput of children in the home, which hampered the provision of the consistency and stability required for medium to long-term care of older children. The home also had to deal with periods of over-occupancy and staff shortages.

13 The impact these circumstances had on the care that could be provided in the home and the pressures on staff were clearly and consistently identified through internal monitoring and external inspection of Fort James. To set the context for our consideration of the home we will briefly note these circumstances as they were identified through contemporaneous monitoring processes.

Arrangements for Internal Monitoring and External Inspection of Fort James

14 In accordance with the Conduct of Children's Homes Direction (Northern Ireland) 1975 the WHSSB had a duty to ensure that each of its children's homes was conducted in such a manner and on such principles as would further the wellbeing of children in the home. The WHSSB put arrangements in place for the regular monitoring of Fort James and invested significant resources in this monitoring throughout the 1980s and up until the home closed in 1995.

15 Part of the monitoring arrangements was the provision of a monthly report on the home by a visiting social worker. This duty was allocated to a senior member of social work staff, TL 4, first in his role as Senior Social Worker (Residential and Day Care) and then in his subsequent role as Assistant Principal Social Worker (Child Care). TL 4 visited Fort James regularly and submitted a monthly written report on the home to his managers using a standard format to record his observations and conclusions.[5]

5 FJH 6812.

16 In addition, from 1988 onwards, managers senior to TL 4, Gabriel Carey and then Robert Dunseath, undertook management audit visits to the home approximately every six months. Both these senior managers produced detailed reports of their audit visits to Fort James[6] which they provided to their management colleagues.

17 Directors of Social Services also occasionally visited the home and contemporaneous documentation shows that they tended to follow up these visits with memos to senior colleagues about any matters of concern.

18 In addition to monitoring by managers, a member of the WHSSB's Personal Social Services Committee visited the home on a regular basis and completed a brief proforma recording his/her findings, which were then reported to the Committee.

19 The Department of Health and Social Services (the Department) was responsible for the external scrutiny of the home. Records of this external scrutiny are not available for the period 1973 to 1982, but inspections of the home were undertaken by the Social Work Advisory Group (SWAG) in 1982 and 1986, and by the Social Services Inspectorate (SSI) in 1987, 1991 and 1994.

Challenges Fort James Faced in Meeting its Remit

20 In spring 1981 the then Director of Social Services, Ronnie Carroll, inspected Fort James to examine the professional functioning within the home. In a memo he sent to Tom Haverty, the then District Social Services Officer, about his visit he acknowledged the aspiration of the staff that the home should concentrate on offering care for periods ranging from six months to three years for older children. However, he pointed out that the wide variation in the ages of children admitted to the home and in the lengths of their stays affected the programmes of care that could be planned and put into operation. He recognised that the shift to caring for older children for longer periods would require an increase in emergency fostering and the number of long-term foster placements. Mr Carroll asked Mr Haverty to undertake a review of fostering resources to ascertain how many foster parents would be willing to accept shorter placements and emergency placements, particularly for pre-school children.[7]

6 FJH 6751.
7 FJH 6555.

21 Despite this intervention, the SWAG team that inspected Fort James in 1982 concluded that the home's aims and objectives to provide medium to long-term care for older children were being undermined by the need to accept emergency admissions. Inspectors found that between January 1981 and September 1982 a total of 34 children were admitted to Fort James. Twenty of these admissions were unplanned and arranged at short notice and ten of the eighteen admissions received between January and September 1982 were emergencies. The inspectors recorded the view of the officer-in-charge, which echoed that of Mr Carroll, that unplanned admissions and uncertainty about the duration of placements in the home was making it difficult to implement planned programmes of care for individual children. The inspectors recommended that the frequent use of the home for emergency admissions was reviewed urgently.[8]

22 Staff shortages were also a problem at times in Fort James. The monitoring of the home by members of the WHSSB's Personal Social Services Committee and the reporting on this monitoring to the Committee meant that this difficulty was known at the highest level of internal governance. For example, Mr P D McAleer recorded in the report of his visit to Fort James on 4 December 1982 that "there continues to be a severe shortage of staff".[9]

23 To further the remit of caring for older children, the accommodation in Fort James was renovated in late 1984 to provide self-contained flats on the site which were used to assist young people to prepare for leaving care. The addition of these flats increased the total capacity of the home to twenty-one.[10] When the home was inspected in 1982 inspectors recorded that the major problem was shortage of staff rather than the use of the home for emergency placements. By the time of the follow-up visit to the inspection which took place in October 1984 the inspector recorded that the staffing establishment had been increased by two senior house parents and two house parents and the number of emergency placements had reduced.[11] However, FJ 33 who was appointed as officer in charge of Fort James in May 1984 told us that during his period as officer in charge the home continued to have to accept a range of emergency and short-term assessment placements. He recalled that staff had to work with children who ranged in age from five to eighteen years, who had a variety

8 FJH 6619.
9 FJH 6561.
10 FJH 40908.
11 FJH 5263-5264.

of care needs, including some learning disabilities, and that the lengths of their stays varied from short to medium to long-term. He explained that this complex mix of children made it very difficult to meet their needs.[12]

24 Throughout the 1980s and into the 1990s these difficulties persisted and were recognised and recorded by senior managers who visited the home regularly. For example, Robert Dunseath, Principal Social Worker (Child Care) recorded in his monitoring report of the home for the period April 1989 to March 1990, that twelve of the total of fifteen admissions in that period had been directly from the community and were due to the lack of available alternative placements. He recorded that three children in the home were aged between five and nine years and four children were aged between ten and fourteen years. He observed that this position reflected the overall increase in the number of admissions of children to care in the area and concluded that if the level of demand for care was sustained there could be implications for the role and function of Fort James.[13]

25 A similar state of affairs was recorded in the 1991-1992 monitoring report, which identified that six of the eleven admissions in that period were emergency admissions direct from the community and that this reflected:

> "a trend identified in the last few monitoring reports of Fort James not meeting its core role as a long-stay unit being used for children moving from Harberton House".[14]

The report concluded that while the formal aims and objectives of Fort James remained unchanged, in practice it was being used predominately as an emergency reception centre rather than as a long-stay unit for adolescents preparing to leave care.[15] The impact on Harberton House of not being able to transfer children to Fort James will be considered later in this chapter.

26 Despite its continued inability to meet its stated remit, the home was further developed and restructured on the basis of that remit. By the time of the SSI inspection in 1994 the home had been divided into two units: an Adolescent Resource Team which was expected to provide a service from reception to long-stay care to address the assessed needs of twelve young people

12 Day 124, p.15.
13 FJH 6758-6794.
14 FJH 6966.
15 FJH 6966.

aged thirteen years and over; and, a Leaving and After Care Team which was expected to prepare four young people to leave care and to provide a supportive/crisis intervention service for those who had left care.[16]

27 However, the inspectors found that despite the redesign of the services being offered in Fort James the home was still not meeting its aim of caring only for children aged over thirteen years. Inspectors noted that eight of the 31 admissions made in the year prior to the inspection were of children aged less than eleven years. Inspectors also noted that in the previous year the home had to cope with a group of young people with very different needs, and that the throughput of children with 31 admissions and 37 discharges had created considerable disruption for the young people requiring long-term care.

28 The inspectors recorded that they had heard from staff and residents that there had been major control problems in the home during most of 1993. They suggested that one possible explanation for this unsettled and volatile situation could be the number of admissions and discharges and the resulting disruption this caused to the residential group.[17]

29 The inspectors also commented that the level of throughput and the practice of caring for adolescents on short-term and long-stay placements within one residential team, raised questions about how the "assessed needs of residents could realistically be addressed".[18] They noted that a proposal had been made by the team leader to use the bungalow in the site as a reception unit to separate the groups given their different needs, but that this plan had not been progressed because of cost implications.

30 The first recommendation in the report of the inspection was that the aims of Fort James should be reviewed and a statement of aims and objectives established that should inform decisions relating to admission and the admission process.[19] This recommendation was made in the knowledge that active consideration was being given to the closure of Fort James. Staff had informed the inspectors that the WHSSB, as part of its Purchasing Prospectus 1994/1995 – 1996/1997, intended to reduce its residential childcare places by fourteen beds over a three-year period and that the closure of Fort James, which would enable a reduction of sixteen beds, was being considered.

16 FJH 40261-2.
17 FJH 40283.
18 FJH 40262.
19 FJH 40299.

31 Given the obvious high level of demand for placements in Fort James, inspectors urged in the inspection report that any plan to close the home was 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 children's homes within the Board's area."[20]

32 The Department, appropriately in our view, followed up these concerns in writing to the WHSSB cautioning against closure of the home in the absence of any rapid development of fostering services, and pointing out the impact that closure could have on Harberton House.[21] Despite these concerns, the WHSSB continued with its plans and Fort James was closed on 31 March 1995.

33 We noted with concern that despite the high level of internal monitoring and external inspection of the home, recurring concerns about:

- the mix of children in Fort James in terms of age;
- needs and length of stay;
- over-occupancy;
- low staffing levels;
- the impact of emergency placements; and
- lack of fostering provision

were never fully addressed or resolved. During our consideration of Fort James the question arose about whether this was in part due to a historical underfunding of the north west of the province, which meant the WHSSB could not provide the full range of foster and residential childcare increasingly required of it in the 1980s and early 1990s. We address that question more generally in the section about Finance in Volume 1.

34 We will now consider the evidence we received from applicant witnesses about Fort James and the police investigations into alleged sexual abuse by FJ 5, an officer in charge of the home.

20 FJH 40299.
21 FJH 40055.

Evidence of HIA 108 about her time in Fort James

35 HIA 108 was initially admitted to Harberton House on 11 October 1980 when she was eleven years old, as an emergency application under a place of safety order. A case conference was held on 24 October 1980 and it was agreed that Fort James would be a more suitable placement for her. She was admitted to Fort James from Harberton House on 3 November 1980 and discharged to her parents' care just under a month later on 1 December 1980.

36 In her written statement, HIA 108 described Fort James as badly run with an aggressive, noisy atmosphere.[22] When she gave evidence in person she described the home as chaotic and referred to the mixture of young and older children and the aggressive behaviour of the older boys.[23]

37 Her specific complaint about the home was that a priest, SND 67, who she alleged had previously sexually abused her in a parochial house in Strabane and in Termonbaca children's home in Londonderry, was allowed access to her in Fort James and continued to abuse her there. She told us that shortly after she arrived in Fort James SND 67 met her when she was out walking with a member of staff and other children from the home. She said the member of staff told her that SND 67 had been asking about her and commented that he was a lovely man. HIA 108 said that four or five days later SND 67 came to visit her in the home and she was taken to a small meeting room and left alone with him. She said that on that occasion he did not abuse her, but that on subsequent visits to the home he sexually abused her, including digitally penetrating her back passage and causing her to bleed.[24]

38 HIA 108 stated that when she tried to resist seeing SND 67 staff told her he was well-intentioned and that she was being disrespectful. She said that on one occasion when SND 67 visited she tried to physically resist being sent to meet with him and a member of staff, FJ 1, twisted her arm in order to make her do so. HIA 108 told us that SND 67 talked in a friendly manner to staff in Fort James, was given tea when he visited and prayed with some of the staff. She stated that the attitude of the staff towards SND 67 meant that he was able to continue to sexually abuse her two to three times a week while she was resident in Fort James.

22 FJH 030.
23 Day 12, p.63.
24 FJH 031.

39 HIA 108 said she told her key worker, SND 501, who was based in Harberton House that SND 67 had come to see her and that SND 501 had replied it was nice of a priest to call and see if she was okay. HIA 108 said she nodded as if she agreed with this view because "she did not feel the Welfare understood or cared about what was going on with her."[25]

40 The HSCB responded to HIA 108's evidence and confirmed that there is no record of HIA 108 informing her key worker about the alleged abuse.[26]

41 SND 67 gave evidence in person during Module 1 to respond to the allegations made about him by HIA 108. He stated that he had no connection to the area where Fort James was situated and would have had no reason to be walking in that area. He said he had no recollection of visiting Fort James in any capacity, and certainly not as described by HIA 108. He specifically stated that he did not visit the home eight to twelve times in a one-month period.[27]

42 FJ 7 worked in Fort James from 1975 to 1990, but was absent from the home undertaking the Certificate in Social Services Certificate when HIA 108 was resident in the home. She explained that visits would have been recorded in the home's diary.[28] However, as the diaries and log books maintained in Fort James prior to 1980 were not retained it was not possible for us to confirm, or otherwise, whether SND 67 visited the home. FJ 7 told us that during the time she worked in Fort James she could only remember one priest paying a one-off visit to the home to meet with a girl preparing for her confirmation and she confirmed that it was a local priest not SND 67 and that the girl was not HIA 108.[29]

43 We carefully considered the evidence that HIA 108 provided about her time in Fort James and we found no evidence of systemic failings in the care she received in the home.

Evidence of HIA 60 about his time in Fort James

44 HIA 60 gave evidence in Module 5, as his evidence about his time at Fort James was not heard when he appeared in person in Module 1. He confirmed that he stayed at Fort James from September 1980 until July

25 FJH 031.
26 FJH 825.
27 SND 14215.
28 Day 128, p.4.
29 Day 128, p.5.

1981 and that he was over seventeen years of age when he was admitted. Initially he shared a bedroom but half way through his stay he was moved to an independent flat on the third floor of the building to help him prepare for leaving care. He confirmed he took care of himself in the flat and prepared his own meals.

45 HIA 60 told us that a member of staff, SND 541, came into his room on a Sunday morning and made reference to him being a Jew. He said he responded by referring to her being married to an "orange bastard RUC man". He explained when he gave evidence that he was particularly upset by SND 541's comment because he considered it a slur on his father who had recently died. HIA 60 stated that on the following Wednesday, SND 541's husband, SND 542, arrived at the home, told him to come outside to have a chat, and then proceeded to punch him on the back of the head and face. He stated that three other members of the RUC were in a parked car in the grounds of the home. He described two of these men getting out of the car and running towards him while the third drove the car into the back of his legs so that he was thrown over the bonnet of the car. He told us that SND 542 and the two officers outside the car then proceeded to kick and punch him and that the beating only stopped because the husband of a member of staff SND 450 arrived to collect her from work and intervened on his behalf. HIA 60 said he was left with minor injuries consisting of cuts and bruises, and that he did not report the matter as he felt there was little point in reporting RUC officers to the RUC.[30]

46 In response to this allegation the HSCB explained that it had no record of a SND 541 working in Fort James, but that some former employees of the home remembered SND 449 working in the home. When FJ 7 gave evidence she confirmed that SND 449 worked in Fort James at the relevant time and that SND 449's husband, SND 448, was a police officer. She also confirmed that she saw no record in the log books of the events described by HIA 60 and that she would have expected such events to have been recorded.[31]

47 The HSCB also stated that it was unable to confirm that a member of staff called SND 450 was employed at the home at the time of the alleged incident, but there was a reference in a document[32] that in 1983, subsequent to the time that HIA 60 was resident in Fort James, a lady called

30 Day 126, p.17.
31 Day 128, p.20.
32 FJH 5338.

SND 450 was working in the home as a temporary house parent. However, in documentation provided to the Inquiry about Fort James, unrelated to HIA 60, we found references to a lady called SND 450 working as a key worker in Fort James between early 1980 and 1982.[33]

48 The HSCB pointed out that there are no entries in HIA 60's social work case records about the incidents described by him or any reference to the injuries he said he suffered.[34] HIA 60 explained when giving evidence that he had not told his social worker, SND 466, about the incident because he did not have a good relationship with him.[35]

49 HIA 60 also described an incident when he accepted money from a younger boy who was a resident in Fort James in the mistaken belief that the boy had received the money from his father, whereas he had actually stolen it from a car. HIA 60 said he was questioned by the police as a result of this incident and told he would be sent to St Patrick's Training School. He said he found out later that his social worker, SND 466, had made an application to the court for an order to send him to a training school but the Judge had rejected it.[36]

50 The HSCB told the Inquiry that it has no record of HIA 60 being interviewed by the police about missing money. It confirmed that consideration had been given to applying for a training school order for HIA 60 because of his disruptive behaviour in Fort James but it was decided it would be inappropriate to do so because HIA 60 was over seventeen years of age.[37]

51 Twelve days after his eighteenth birthday, HIA 60 was housed in a bungalow that had been allocated to him by the Housing Executive in response to an application for emergency housing which had been made on his behalf. He told us that when he returned to Fort James to collect his belongings a member of staff, FJ 7 told him through a locked office window that he was discharged from Fort James with immediate effect. He said all his personal belongings were put in two bin liners outside the front door as if they were rubbish and that he was not afforded the dignity of packing his own belongings.[38] The HSCB told us that it has no record of events

33 FJH 30996.
34 FJH 375.
35 pp. 20-21, Day 126, 15 June 2015.
36 FJH 377.
37 FJH 377.
38 FJH 020.

surrounding HIA 60's discharge from Fort James, but accepted that at that time it was not unusual for young people's belongings to be put into large plastic bags when they were moving into their own accommodation. The HSCB explained that this practice ended once residential homes were allocated petty cash, which enabled them to purchase holdalls for young people to use to transfer their belongings.[39]

52 We have carefully considered the evidence that HIA 60 provided about his time in Fort James, and it is clear from what he told us and our consideration of records provided by HSCB that it was an unsettled time for him and that his relationships with staff deteriorated while he was in the home. We consider it poor practice that HIA 60's belongings were packed into two bin liners but accept the HSCB's explanation for why that was the practice at that time. We did not find evidence of systemic failings in the care that HIA 60 received in Fort James.

Alleged Sexual Abuse by FJ 5

53 FJ 5 commenced employment as the officer in charge of Fort James on 2 September 1980, and remained in that post until 1 August 1983. On 7 October 1983 a former resident of Fort James, FJ 30 told his social worker FJ 41 that he had been sexually abused by FJ 5 while he was a resident in Fort James.[40] FJ 30 told FJ 41 that the sexual abuse started when he was on holiday with FJ 5 in Wales, continued following their return to Fort James and had only ended approximately a year before his disclosure to her. He explained that he had not told anyone about the abuse while he was resident in the home for fear of the outcome. He said he still felt confused and angry about what had happened but decided to tell her about it because he had recently viewed a documentary about venereal disease and was frightened he had contracted the disease from the sexual contact he had with FJ 5. FJ 41 explained to FJ 30 that she would have to inform her senior managers about what he had told her and also involve the police. FJ 30 accepted this.

54 FJ 41 reported the allegations to her senior managers and Mr Dunseath and Mr Victor Hutchinson, Assistant Principal Social Worker (Fieldwork) accompanied her on a further visit to FJ 30 at his flat on 12 October 1983[41] to gain more details about the alleged abuse. Following that

39 FJH 378
40 FJH 30377-8.
41 FJH 627.

meeting a case discussion was held on 18 October 1983 where it was decided to refer the matter to the police.[42]

55 FJ 5 was living in Wales at this time and on 2 November 1983 he provided a statement, under caution, to police in Wales about the allegations made by FJ 30.[43] He explained that when he commenced work in Fort James a very aggressive and threatening group of teenagers were in residence, and that most of them were older and bigger than FJ 30. He described FJ 30 as having a very troubled background and that his response to the behaviour of the other residents was to isolate himself for protection. He explained that FJ 30 achieved some of this isolation through creating a garden and tending chickens and when he became aware that FJ 5 had some knowledge and experience about both these activities he frequently and persistently sought his advice and help.

56 FJ 5 also told police that FJ 30 had difficulty sleeping at night because of experiences he had as a young child, and that a pattern had emerged where he stayed up talking to the night worker and went for walks in the garden during the early morning. FJ 5 explained that he considered this behaviour should not be encouraged or allowed and therefore established an alternative bedtime routine for FJ 30 which included staff reading to him.

57 FJ 5 told the police that FJ 30 developed a dependency on him, would constantly seek him out even when he was off duty, and would become extremely abusive and aggressive if he was denied access to him. He stated to the police:

> "Due to the fact that there was a heavy burden in terms of time and effort needed for FJ 30 and the fact that there was a severe shortage of senior staff available my contact with FJ 30 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".[44]

58 FJ 5 admitted to the alleged offences and said they occurred during the peak of a period when he had been working an excessive amount of overtime, which he described as working 24 hours a day seven days a week. He said the offending behaviour occurred on three or four

42 FJH 631.
43 FJH 30381.
44 FJH 30385.

occasions, that it involved mutual masturbation on one occasion and on the other occasion he masturbated FJ 30. He said that FJ 30 anally penetrated him on two occasions but that he never anally penetrated FJ 30. FJ 5 indicated that these offences occurred in FJ 30's bedroom in Fort James.[45] FJ 5 told the police he regretted deeply what had occurred and had made every attempt to do what was in FJ 30's best interest before and since. FJ 5's account was different from the account FJ 30 gave to police in Londonderry, where he stated that FJ 5 had anally penetrated him and that some of the sexual abuse occurred when he was on holiday with FJ 5 in Wales.[46]

59 The WHSSB established a review group, chaired by Mr Haverty, District Social Services Officer, to consider the circumstances surrounding FJ 5's alleged abuse of FJ 30 and to look at the detail of FJ 30's period in care.[47] As part of this review, an interview was carried out with FJ 7 who had been appointed acting officer in charge of the home on 7 December 1983.[48] FJ 7 explained that she had been completing her studies to attain the Certificate in Social Services for some of the period in which FJ 5 had been the officer in charge but had helped out in the home during her studies. She said that the home was understaffed, staff were under a great deal of pressure and that FJ 5 in particular was very tired and had fainted on a couple of occasions in the home.[49] She was anxious to point out that during the period FJ 5 was officer in charge of the home he initiated positive developments, such as the introduction of the key worker system and greater contact between the home's staff and social workers and foster parents.

60 Another member of staff, Eileen Wiley, was interviewed and she described the staffing situation when she started working in Fort James in February 1982 as "chronic". She said that FJ 5 was exhausted and at times he was also sick.[50]

61 Anne McDermot, who had commenced work in Fort James in September 1982, was interviewed[51] and commented on the lack of staff in the home, the negative effect this had on staff and on the children who she felt did not get sufficient personal attention.

45 FJH 30385.
46 FJH 30360-30366.
47 FJH 30990.
48 FJH 30990-3.
49 FJH 30991.
50 FJH 30994.
51 FJH 30995-6.

62 FJ 40, who had been FJ 30's key worker from early 1980 to April 1982 was interviewed[52] and also commented on the low staffing levels in the home between 1979 and 1982 and how at times it had meant there was only one member of care staff and one member of management staff on duty. She confirmed that staff were under considerable pressure and that FJ 5 did a great deal of overtime. She said that FJ 5 was always caring toward the children and that she received good support and supervision from him, including assistance with any problems she experienced in working with FJ 30.

63 In relation to FJ 30's absences from the home she recalled that he went on holiday with FJ 5 in March 1981 to Wales and that she thought they stayed at the house of a friend of FJ 5. She explained that prior to this trip FJ 30 shared a room with another boy, but following the trip the other boy moved out of the room and FJ 30 was left alone in the room. She stated that she believed FJ 30 was allowed to have sole occupancy of the room for professional reasons as he continued to be very deprived, demanded a great deal of attention and staff were still reading to him in bed.

64 She explained that in July 1981 FJ 5 took a group of five children on holiday to Wales and that initially he was not going to allow FJ 30 to go on the trip because of his poor behaviour, but that his behaviour improved and he was eventually allowed to go. She recalled two further trips when FJ 5 took FJ 30 on trips outside of Northern Ireland, but indicated that both trips had been agreed in advance with FJ 30's social worker, FJ 41. The first trip was in May 1981 when FJ 5 took FJ 30 to London for an interview at the community service volunteers' office. FJ 40 said that FJ 41 was heavily involved in arranging this trip and had agreed that it was more appropriate for FJ 5 rather than her to accompany FJ 30 to the interview. FJ 40 explained that FJ 5 and FJ 30 were away for a few days and she understood that after the interview they went to Wales for a couple of days. The second trip was when FJ 30 visited FJ 5 in Wales in February 1982. FJ 40 explained that this trip was arranged because FJ 5 was going on an extended trip to Thailand and FJ 30 was very upset at the idea of FJ 5 being away from Fort James for so long. FJ 40 indicated that these trips would have been mentioned at reviews and recorded in the log book.

52 FJH 30996-8.

65 In a memo dated 27 April 1984 Mr Haverty recorded notes about the conclusions of his review[53] in which he acknowledged the adverse impact that understaffing in the home, and particularly lack of senior staff, had during the relevant period. He recommended the establishment of a system to enable the senior staff in the home 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 children in the home. Mr Haverty also pointed out that it was evident that staff had not been receiving supervision regularly enough and, while he expected this to improve given increased staffing levels in the home, it would be necessary to monitor on a regular basis the level of, and effectiveness of supervision of, staff in the home.

66 He also concluded that there was a need for greater clarity about roles and responsibilities in the home, including the responsibility of district staff and those involved in quality assuring the home. In particular, he stated that district staff should be informed about changes in the systems for management of the home.

67 We noted with interest Mr Haverty's suggestion that consideration should be given to permission for children leaving the home to be further delegated to the officer in charge.[54] We considered this a surprising recommendation given that FJ 5 was the officer in charge when he was taking FJ 30 on holidays outside Northern Ireland.

68 In a memo dated 17 April 1984, Mr Carroll, the then Director of Social Services wrote to Mr Haverty to comment on the notes Mr Haverty made during the review that had been shared with Mr Carroll. In particular, he referred to the note of the interview with FJ 40 in which she was recorded as saying that she was concerned about FJ 30, and phoned him in Wales to see if he was all right because other children in the home were calling FJ 5 "a big queer". Mr Carroll queried why FJ 40 did not see fit to report her concerns to more senior management.[55]

69 FJ 5 was charged with buggery and aiding and abetting buggery contrary to Section 61 of the Offences against the Person Act 1861, as amended by the Homosexual Offences (Northern Ireland) Order 1982. His case

53 FJH 30986-7.
54 FJH 30987.
55 FJH 30983.

was heard from 11 September to 20 September 1984 in Londonderry.[56] Following the presentation of the prosecution's case the trial judge gave a direction to the jury on 20 September 1984 that the verdict should be "not guilty" on every count. The *Derry Journal* reported that the complainant had asked the jury to disregard his evidence given under oath in the witness box and instead refer to his statements made to the police about nine months previously and that the trial judge had stated that under these circumstances he had no alternative but to ask the jury to record a verdict of "not guilty".[57]

70 FJ 33 was the officer in charge of Fort James at the time of the court case. He told us that staff were positive about FJ 5 and felt he had improved the practice in the home and promoted a more child-focused approach. He said they were shocked about the allegations made against FJ 5 and when the case collapsed they were left confused and wondering whether the alleged abuse had happened.[58]

Conclusions about Fort James

71 Throughout the majority of time that Fort James operated it could not meet its agreed remit because of the impact of emergency placements, over-occupancy and the mix of children in relation to age, need and capabilities. We recognise that some of these circumstances were created by unforeseen factors that could not have been anticipated in strategic planning such as the discovery of a network of sexual abusers in Derry which made a number of emergency placements necessary. We also accept the point made by the HSCB through the Warning Letter process that finding suitable foster parents particularly for older children and children with sexualised behaviour was a difficult task and that the Foster Care Unit made significant efforts, particularly post January 1990, to develop fostering resources. We also noted the efforts made, for example in 1983/84 to increase the staffing levels in the home and reduce the number of emergency placements. Nevertheless, staff, senior managers, members of the Board who visited the home and inspectors consistently raised concerns about the impact emergency placements, over-occupancy and the mix of children in relation to age, need and capabilities were having on the quality of care provided to the children in the home. **We consider the WHSSB's failure to effectively**

56 The Chairman of the Inquiry withdrew from discussion of this case as he appeared as counsel in the court case.
57 *Derry Journal* 21 September 1984.
58 Day 124, p.10, 10 June 2015.

address these issues, which were clearly having an adverse effect on the appropriateness and level of care that could be given to children in the home, amounted to a systemic failure to ensure that Fort James provided proper care.

72 Despite the high level of monitoring of the home, staff and in particular the officer in charge were allowed to work excessive overtime for extended periods. We consider that the implications of such work patterns for the quality of care that can be provided to children should have been understood and addressed by senior managers. FJ 7 and FJ 33 told us that FJ 5 recorded the levels of staff overtime and made the case for additional staff. We noted that in a memo dated 20 August 1981 from FJ 5 to Tom Haverty, he stated he was stressing a point he had made before:

> "…that Fort James is severely understaffed. The type of therapeutic approach we are attempting to take could be a futile exercise; lack of staff time may sabotage the very great effort made by the team".[59]

We consider the WHSSB's failure to address the excessive overtime worked by staff, in particular by the officer in charge, and the implications such work patterns had for the quality and safety of the care provided to children in the home, amounted to a systemic failing to ensure Fort James provided proper care.

73 We consider that the WHSSB acted appropriately in referring the allegations about FJ 5 to the police, reviewing the circumstances surrounding the period that FJ 5 was officer in charge of the home and identifying action to improve practices within the home and the management and monitoring of the home by district staff.

74 We noted that when FJ 30 was interviewed by senior managers following his disclosure to FJ 41 he told them that his close relationship with FJ 5 was noticed by staff and other children and led to him being ostracised.[60] He also said that the other children implied FJ 5 was "queer" or gay and called him "fanny" and that they also referred to FJ 30 as gay because of his openly close relationship with FJ 5.[61] When FJ 40 was interviewed by senior managers she told them she heard children talking in this way about FJ 5 and as referred to above she was sufficiently concerned about FJ 30's wellbeing to telephone him when he was in Wales with FJ 5 to check that he was all right.

59 FJH 6558.
60 FJH 627.
61 FJH 627.

The HSCB pointed out through the Warning Letter process that in the context of a residential home setting it was inevitable that children would on occasion refer to a staff member in derogatory terms which would be difficult to control in any setting involving a number of children. We accept that may be the case but consider that the children's references to FJ 5's close relationship with FJ 30 and their related inferences about FJ 30's sexual orientation should have caused concern and been addressed by staff.

75 We found no evidence that any staff member raised the appropriateness of FJ 5's relationship with FJ 30 and the other children's perception of it with FJ 5 or referred any concerns about these matters to senior managers. **We consider this lack of action by staff to be a systemic failure to take all proper steps to prevent, detect and disclose abuse.**

76 We also found no evidence of senior managers questioning why the officer in charge was playing such a central role in the care of one resident, including taking him on trips outside Northern Ireland on a number of occasions. Setting aside any suggestion of a sexual relationship, we consider that senior managers who were in regular contact with FJ 5 as the officer in charge should have questioned the implications of his very close relationship with one child, not only for that child but also for the management of the home and the other children and staff's perceptions of him as the officer in charge. We found no evidence that this happened and we consider the effectiveness of the considerable monitoring of the home by district staff has to be questioned if relevant matters about the practice of the officer in charge were not identified, or if identified, were not addressed.

Summary of Findings about Fort James

77 **We found that the WHSSB's failure to:**

(1) effectively address strategic issues in relation to the provision of residential childcare and lack of foster care, which were clearly having an adverse effect on the appropriateness and level of care that could be given to children in Fort James; (Para. 71)

(2) address the excessive overtime worked by staff, in particular FJ 5 the officer in charge, and the implications such work patterns would have for the quality and safety of the care provided to children in Fort James; (Para. 72) and

(3) question the appropriateness of FJ 5's close relationship with FJ 30 and respond seriously to comments from children in the home about that relationship and about FJ 5 and FJ 30's sexuality, (Para 75)

all amount to systemic failings by it to ensure Fort James provided proper care.

Part Two:

Harberton House

78 As we explained at the start of this chapter, we decided to have a focused consideration of Harberton House because of incidents of peer sexual abuse that took place there and the evidence provided by HIA 233 about her time in the home. Before turning to these matters it is relevant to consider first the establishment and remit of Harberton House and the context in which it was operating when the peer sexual abuse occurred.

79 Harberton House was a purpose-built residential unit with a capacity for 25 children. It was opened on 8 September 1980 and the first children were admitted on 19 September 1980. The home was designed to provide a short-stay period of planned assessment for children in order to identify their care needs and develop plans to meet them. The home was also expected to provide emergency placements for children. Although the home was based in, and managed by, the Londonderry, Limavady and Strabane district, its facilities were available for use by Omagh and Fermanagh districts.

80 HH 22, the first deputy officer in charge of Harberton House, referred in her written statement and oral evidence to the planning of Harberton House and preparations for its opening, and commented that it was seen as an exciting initiative and one she wanted to be part of from the start.[62]

81 As Harberton House was planned as a short-stay assessment unit the procedures developed for its operation focused on making sure a period of assessment was necessary and appropriate for a child and that the fullest use was made of the time-limited period children were expected to spend in the home.

82 A Core Evaluation Team was established to meet weekly to:

(1) consider applications for assessments of children;

(2) discuss any relevant matters pertaining to the children in the home; and,

(3) discuss the assessment of each child's needs and agree plans for their future care.

62 FJH 40182.

83 The Core Evaluation Team was chaired by HH 40, the Senior Social Worker, Residential Child Care. Initially, the other members were Dominic Burke, then Principal Social Worker (Fieldwork) or Mr Hutchinson, Assistant Principal Social Worker, (Fieldwork); HH 5, officer in charge of the home, and his deputy HH 22, Dr Munroe, Medical Officer and one of a team of educational psychologists. Mr Newman, Assistant Director of Social Services, was also recorded as attending meetings of the team.[63]

84 Social workers who wanted to refer children for assessment were expected to attend a meeting of the Core Evaluation Team to present and discuss their referral. Once a child was accepted for assessment a member of residential staff in Harberton House was appointed as key worker. The key worker liaised with the field worker and met with the child and his/her family to help them understand and prepare for the assessment process. The involvement of the child's family was seen as key to the assessment approach, and they were expected to attend weekly meetings at the home, which the child's field social worker was also expected to attend.

Review of the First Six Months of Operation of Harberton House

85 Although the plans and procedures for the home were designed on the basis that it would operate primarily as an assessment centre it became clear only six months after it opened that it was mainly being used for emergency placements. HH 40, the first chair of the Core Evaluation Team, undertook a review covering the first six months of the operation of the home, from 19 September 1980 to 28 February 1981. In the report of his review[64] he recorded that in the first six-month period 62 children were admitted to the home, but only ten of these children were admitted for assessment on a planned basis following approval of an application for assessment by the Core Evaluation Team. The other 52 children were admitted on an emergency basis, without referral to the Core Evaluation Team. HH 40 noted that although some of these admissions were a result of an unexpected crisis in a child's life that necessitated immediate action, others were required because appropriate alternative placements could not be secured for children whose circumstances and needs were known.

63 FJH 20928.
64 FJH 20925-33.

86 Ten of the 52 children admitted as emergency placements remained in the home to be assessed, while the remaining 42 children were held without being assessed until alternative placements were obtained for them. Although the procedures agreed for Harberton House were based on children admitted on an emergency basis staying no longer than one week, the average length of stay of these 42 children was three and a half weeks, and the length of stay ranged from one day to twelve and a half weeks. The 42 children ranged in age from young babies to adolescents, and HH 40 recorded that the three cots for young babies were mostly in use over the six month period.

87 On the basis of these figures, HH 40 concluded in his report:

> "Before concentrating on the functioning of Harberton House as an Assessment Centre, it is necessary to recognise that in practice it has a dual function. It is a reception unit as well as an assessment unit, and in fact it is clear from the figures that in practical terms its primary function of assessment has been dwarfed by its role as a reception unit over this six month period."[65]

88 HH 40 identified that the demand on Harberton House to accept emergency admissions had been increased by changes to other children's homes in the area: by St Joseph's Termonbacca closing its nursery; and by Fort James working to change from a children's home to a medium to long-stay treatment unit for adolescents. He also identified that the large number of children being received into care could not be accommodated by already limited foster care provision, and that there was a gap in the present provision for young babies, children and adolescents who because of their religious denomination could not be placed in voluntary homes run by Catholic orders.[66]

89 HH 40 recommended that fostering provision should be extended and that the staffing levels in Harberton House should be reviewed, given the increased workload on staff dealing with emergency admissions, many of which involved babies or pre-school children whose care was resource intensive. He also noted that the demands of providing care to children on emergency placements meant that staff time was directed toward the care of these children, rather than planned work with the children who had been referred specifically to Harberton House for assessment.[67]

65 FJH 20926.
66 FJH 20926.
67 FJH 20932.

90 HH 40 also acknowledged that, as well as practical difficulties in the first six months of the home's operation, questions of principle had been raised by fieldwork staff and members of the Core Evaluation Team about whether the planned focus on assessment was appropriate. He noted that it had been suggested that procedures should be revised to allow the home to act as a treatment resource as well as an assessment centre.[68]

Formal Review of Harberton House in 1984

91 Although the barriers to Harberton House fulfilling its planned remit as an assessment centre were identified and analysed as early as six months into its operation, it took until 1984 for a more formal review of its function and operation to be carried out. We noted the remit of the working party established to review the home at that time and its conclusion from the references to them in the report of the SWAG's inspection of the home in 1986.[69] We asked the HSCB for a copy of the working party's report but it informed us that it was unable to locate a copy.

92 The remit of the working party as detailed in the SWAG report was:

> "(i) to review the functioning of Harberton House;
>
> (ii) to examine the most appropriate structure to carry out this revised function according to changing need; and
>
> (iii) to devise an appropriate operational plan for this structure."[70]

93 The SWAG inspectors recorded that the working party published its report in December 1984, and proposed that:

> "formal recognition should be given to the evolutionary changes which have occurred in order to meet the needs of children being admitted to Harberton House ie that the unit should be formally divided into:-
>
> (a) a reception/assessment unit with 13 beds; and
>
> (b) a medium stay unit with 12 beds."[71]

94 Although these changes were agreed and implemented on 1 October 1986, following necessary renovations to the property to create two separate units, the throughput of children in the home continued to be a problem. The quality assurance arrangements for the home meant that it was a problem that was recognised at all levels within the WHSSB.

68 FJH 20931.
69 FJH 15429-15465.
70 FJH 15432.
71 FJH 15433.

Governance and Quality Assurance Arrangements

95 The governance and quality assurance arrangements for Harberton House were similar to those that operated in Fort James. TL 4 Senior Social Worker (Residential Child Care) undertook the responsibilities of the visiting social worker in accordance with the Conduct of Children's Homes Directive (Northern Ireland) 1975. TL 4 visited the home on a regular basis, usually seven or eight times in a month and completed a standard monitoring report, which covered occupancy levels, the gender and age range of residents, the quality of primary care and emotional care provided, the maintenance of records, untoward incidents, level of contact between residents and their field social workers and the physical condition of the building. Gabriel Carey undertook audit visits to the home approximately every six months and produced detailed reports of his visits which he sent to the Principal Social Worker (Residential and Day Care), the Director of Social Services and the Assistant Director of Social Services.[72]

96 The reporting of the audit visits was an important means of ensuring that the strategic direction of the home and the challenges it faced continued to be kept on the agenda of senior managers. Although the Core Evaluation Team continued to meet, its focus was on the immediate situations of the children in the home rather than any oversight of how well Harberton House was able to meet its agreed revised remit or related resource issues.[73]

97 In addition to monitoring by senior managers, a member of the WHSSB's Personal Social Services Committee visited the home on a regular basis and completed a proforma report which was shared with members of the committee and senior staff.

98 The continuing problems that Harberton House faced in moving children on to more appropriate and more permanent placements were highlighted through these quality assurance processes. For example, in the report of his visit to the home on 12 September 1989, Mr Carey commented in relation to admissions and discharges to the home:

> "HH 5 again emphasised the need to get some movement, not least to enable staff to concentrate on work they should be doing with children. Prolonged admissions quite often create difficulty when children become somewhat frustrated about the lack of placement opportunities for

72 FJH 782.
73 FJH 11863-12542.

them and perhaps a sense of hopelessness about their situation sets in. This inevitably results in behavioural and disciplinary problems."[74]

99 He also recorded that HH 5 had pointed out that retaining children while more permanent placements were sought meant the ability to accept new admissions was severely reduced, and that in comparison to 1981, when 121 new admissions were accepted, only 49 admissions had been possible in 1989.[75]

100 The issue of lack of throughput of children was also raised with Ms Imelda McGowan, the member of the Personal Social Services Committee who visited the home on a regular basis, when she visited on 22 September 1989. She recorded in her report of that visit:

> "Staff were anxious to develop their family work and move towards use of the Unit for other than residential care. However, shortage of foster parents and places in longer stay Units mean that children who are ready to move on cannot do so. Therefore staff are tied up with the day to day caring role."[76]

As a result of Ms McGowan's comments Mr Haverty, whose title was then Assistant Director of Social Services, wrote to Mr Carey asking for an update in the provision of foster care.[77]

101 Mr Carey responded that he and his colleagues were alert to the difficulties created by the lack of foster care provision, and were aware that at any one time 30 children were waiting for suitable placements. He confirmed that he had a number of discussions with HH 5 about the impact this had on Harberton House. He referred to a sub-group which had been established to consider how £59,000 of funding available for specialist fostering should best be used and that he had made a bid for childcare development funds to appoint an additional home finding post in the fostering team.[78]

102 The demand for residential places continued to grow, and Mr Carey wrote to Mr Haverty on 15 February 1990 about the pressures on field and residential services because of the number of children requiring care. He informed him that from 19 January 1990 to 15 February 1990, 28

74 FJH 40020.
75 FJH 40020.
76 FJH 15344.
77 FJH 15346.
78 FJH 15345.

children had been received into care and ten further children were awaiting admission. He explained that the majority of children in care had been admitted due to neglect, physical abuse, or the inability of parents to provide proper care and not sexual abuse, but pointed out that this did not mean that in relation to these children "disclosure of sexual abuse will not become an issue at a later stage".[79] He reported that the officers in charge of the children's homes had pointed out that because the homes were having to accommodate increasing numbers of children over their approved occupancy rates, staff were not able to give children individual attention, and care had become a holding process. He also reported that the officers in charge had told him that the number of children being admitted to the homes, and the level of disturbance of some of the children, created increased risks to children and staff because it made supervision difficult.[80]

103 The lack of foster placements also continued to be a problem to the extent that HH 42, Senior Social Worker Foster Care, wrote to Mr Carey on 7 March 1990 about the 'Crisis Situation in Foster Care' pointing out that 59 children were waiting for long-term foster placements, eleven of whom were resident in Harberton, and asking for two additional social worker posts to help resolve the crisis.[81]

104 In order to manage the demand for residential care and the placement of children, Mr Carey convened and chaired regular meetings of TL 4, HH 40 and the managers of Harberton House, Fort James and the fostering team to discuss the overall demand for residential care (which often exceeded available places) and to agree what action was necessary. Such a meeting was held on 8 March 1990, the day after the memo referred to above about lack of fostering placements was sent to Mr Carey. Mr Carey chaired the meeting which had to consider how to accommodate four children, all of whom were under six years of age, who required urgent residential care. As no fostering resources were available in the immediate area, the possibility of using fostering resources in Fermanagh was being explored but the meeting concluded that if that proved unsuccessful, the only option was to open the staff bungalow in Harberton House and use it to accommodate the children.[82] This ultimately proved necessary and

79 FJH 15516.
80 FJH 15516.
81 FJH 15493.
82 FJH 15495.

the next day, 9 March 1990, the bungalow was opened to accommodate these children.

105 As well as the challenges created by the number of children requiring care and the barriers to moving children on from Harberton House to appropriate placements, senior managers were also aware of the increasingly complex nature of the difficulties some of the children had experienced and were responding to. For example, in the report of his audit visit to Harberton House in January 1989 Mr Carey observed:

> "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 effected the determination of the staff to do a good job. .....However, overall whilst I am satisfied with the standard 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."[83]

106 The reality of the risks created by the number and range of children placed in Harberton House, the complexity of their needs and the lack of more appropriate alternative placements for some of the children came sharply to the fore when it was identified that co-ordinated peer sexual abuse was taking place in the home.

Peer Sexual Abuse

107 We noted from contemporaneous records that staff in Harberton House were dealing with incidents of peer sexual abuse from as early as 1981. At that time a boy who had been admitted to the home from Termonbacca was being closely supervised because of his sexual interest in and behaviour towards younger boys. In June 1981, the boy, then aged fifteen, admitted to HH 5 who was discussing his general behaviour with him that he had engaged in mutual masturbation on a number of occasions with two younger boys aged nine and eleven years.[84] Staff dealt with this matter through what HH 5 described as "an intensive level of supervision".[85] The boy was also referred to a consultant psychiatrist

83 FJH 20106.
84 FJH 50724.
85 FJH 50725.

in Gransha psychiatric hospital and the psycho-sexual clinic in Belfast City hospital and a clinical psychologist worked with him a number of times in the home.

108 We are aware that further incidents of peer sexual abuse came to the attention of staff in July 1988, when one of the teenage children involved, a thirteen-year-old boy, HH 48, reported the activity to a member of staff. HH 48 explained that he was telling the staff member about the sexual activity because he wanted it to stop. HH 48 and the other boy and girl involved in the sexual activity, who were also aged thirteen years old, were spoken to by staff about their behaviour. The "Untoward Incident Report" completed in relation to the incident recorded that this was not the first incident of a sexual nature involving the three children in recent months.[86] TL 4, Assistant Principal Social Worker, informed Mr Haverty, Assistant Director of Social Services about the incident and recorded that the report "highlights a continuation of sexualised behaviour involving these children".[87]

109 At that time of this disclosure HH 48 had already come to the attention of the police and of the SSI. HH 48 had been admitted to Harberton House on 2 June 1988 on a Wardship Order as a result of non-school attendance. On 9 June 1988 he absconded and returned to his family home in Strabane. When he returned to Harberton House he told staff that while he was in Strabane he was sexually abused by a man who had previously sexually abused him when he lived at home. SND 502, Assistant Director of Social Services, informed Mr O' Brien of the SSI by letter on 27 June 1988 about these allegations and that the accused man had admitted the offences and been arrested.[88]

110 SND 502 wrote to Mr O' Brien again on 25 August 1988 to inform him about the peer abuse that HH 48 was involved in. Mr O'Brien acknowledged receipt of this letter on 28 September 1988 and noted that staff in Harberton House were intensifying their work with the children involved and that the situation was being carefully monitored by the Core Evaluation Team.[89]

111 In October 1988 the man who had been arrested and was subsequently charged with buggery and gross indecency was found hanged in a voluntary

86 FJH 50726.
87 FJH 50727.
88 FJH 50728.
89 FJH 50729.

home for ex-prisoners where he was living pending his court appearance. The WHSSB informed the SSI of this and that HH 48 had named two other men in Strabane who he said sexually abused him and that these allegations were being investigated urgently by the police. It was recorded in an internal SSI memorandum that WHSSB staff were concerned that a vice ring might be operating in Strabane. The internal memorandum considered what notification should be provided to the Minister given that the case might attract media attention. The author of the memorandum suggested that the Minister should be advised about the peer sexual abuse but commented:

> "Such incidents are hardly a rarity but given the boy's background this particular one might attract media attention."[90]

The Minister was informed about the case and told that the WHSSB was dealing with the incidents of peer sexual abuse.[91]

112 Therefore, staff and managers were alert to the risks of peer sexual abuse when other incidents of it came to their attention in March 1990. On the evening of 13 March 1990 a senior house parent, HH 31, pursued an aside made by a nine-year-old male resident over the dinner table about sexual activity between residents. The boy was subsequently talked to by staff. He gave them the names of other children he said were involved in the sexual activity. These children were also spoken to by staff that evening and the next day. Staff attempted to inform TL 4 about the disclosures, but he was unavailable so it was the morning of 15 March 1990 before senior managers were informed about them.

113 HH 32, senior house parent, provided an untoward incident report on 15 March 1990 about the disclosures.[92] In the report HH 32 named eight children, four boys and four girls, aged from seven to thirteen years who had been interviewed about their involvement in the sexual activity. A case conference was held the next day, 16 March 1990, and immediate action was agreed including the children's families being informed, the matter being reported to the RUC and the employment of a waking night member of staff in the home from that evening.

114 From the information provided by the children it became clear that the sexual activity they were involved in included fondling, oral sex, sexual

90 FJH 50732.
91 FJH 50731.
92 FJH 10063-70.

intercourse and bondage. It had commenced in December 1989 and was co-ordinated by some of the children to take place very early in the morning, and in the period around the end of the school day when they knew staff would be occupied with transporting children from school and handover meetings and would therefore be less available to supervise them. The incidents were described as happening in the playroom, bedrooms, the visitor's room and the garden areas at the rear of the home. Children described acting as "lookouts" and behaving in a disruptive way to distract staff attention so that the activity could go unchecked. Although some children described consensual sexual exploration, others described being coerced and frightened into sexual activity.[93]

115 Two of the boys who played a major part in the abuse implicated nine adolescent children resident in the home in it. The police interviewed one adolescent girl who admitted that she organised disruptive situations to distract staff attention so that the sexual activity could take place, but denied engaging in it herself. The police decided not to interview the other adolescent children. Staff did interview them and recorded that they denied any involvement.[94]

116 Mr Carey wrote to Mr Haverty on 26 March 1990[95] to inform him about the disclosures to date and what immediate action had been taken. He reported that the most serious incidents had taken place in the early hours of the morning, and the decision to introduce a waking member of night staff had proved effective but that member of staff had left to take up another job. He explained that consequently an interim measure had to be introduced of one member of sleeping-in staff commencing work at 5am to supervise the children. He also explained that he was exploring the installation of electronic warning systems that would alert staff to children leaving their bedrooms at night.

117 Mrs McGowan, the member of the Community Care Committee who made regular visits to Harberton House visited the home in April 1990. She recorded her view that in light of the peer sexual abuse there was a need to review the adequacy of childcare resources generally within the WHSSB, and particularly within the Foyle Unit of Management because:

> "...we are failing in our duty to protect children – providing a bed, shelter and food is not enough."[96]

93 FJH 11025.
94 FJH 20308.
95 FJH 15575-7.
96 FJH 10011.

118 Since the next meeting of the Community Care Committee was not until June 1990 Mrs McGowan wrote directly to Tom Haverty enclosing a copy of her report.[97] Mr Haverty responded on 18 May 1990.[98] He explained the increased demand for residential care for children since January 1990, acknowledged the untoward incidents in Harberton House and confirmed that the occupancy rate in the home had been reduced to 25 children.

119 Mr Carey wrote to Mr Haverty on 25 June 1990 to update him about the police investigations into the peer sexual abuse.[99] In due course, on 30 October 1990, Inspector McCracken of the RUC wrote to Mr Carey to inform him that the Director of Public Prosecutions had directed no prosecution and that rehabilitation of the children was best left to the Social Services.[100] Mr Carey also took the opportunity to point out that Harberton House had seven children over its occupancy level during the time the peer sexual activity took place, which necessitated the employment of six untrained members of staff. He explained that the number of children that had to be cared for, and the support that experienced staff were required to give to inexperienced staff, meant that the focus was on meeting the primary needs of children rather than engaging in therapeutic work. He suggested that this combination of factors may have explained why the sexual activity was not picked up sooner. He also made the point that the complexity of the needs of the children being received into care increased the need for additional and appropriately trained foster parents.

Involvement of the Department

120 On 23 March 1990, Mr Carey contacted Mr Wesley Donnell of the Child Care Branch of the Department to inform him of the events in Harberton House[101] and SND 502, Acting Director of Social Services, wrote to Mr O' Brien, Social Service Inspector, on 8 May 1990 to formally advise him about them.[102] SND 502 set the incidents of peer abuse in Harberton House within the wider context of the pressures being experienced by the WHSSB because of the increased numbers of children being received into care and the complexity of their needs. She explained that the General Manager and the Area Executive team had agreed the establishment of

97 FJH 10047.
98 FJH 10095.
99 FJH 15568-155740.
100 FJH 11016.
101 FJH 15596.
102 FJH 10270.

two new social works posts in the fostering team and four new social worker posts in Foyle Community which she anticipated would do much to free up the situation in the children's homes. Mr O Brien responded to SND 502 on 18 June 1990. He acknowledged that the increase in admissions to Harberton House may have contributed indirectly to the incidents.[103]

121 Dr McCoy visited Harberton House and Fort James on 26 June 1990;[104] these visits had been arranged prior to the peer sexual abuse being detected in Harberton House. Following these visits there was considerable discussion between Dr McCoy and his senior colleagues about how to ensure a proper investigation of what had occurred between the children in Harberton House. It was clear from the internal SSI communications in October 1988 about the peer abuse involving HH 48 that officials understood the potential for peer sexual activity and abuse in children's homes. However, the number of younger children involved in this case concerned them as did the fact that the sexual activity had gone on for a sustained period without being detected. Consideration was given to whether a formal investigation should be carried out to consider generally the care of sexually abused children in children's homes and to focus specifically on the lessons to be learnt from Harberton House.[105]

122 Subsequently, Dr McCoy telephoned SND 502 and asked her to provide a report on the overall circumstances of the incidents in Harberton House that could be shared for information with the Directors of Social Services of the other Boards. SND 502 told colleagues that Dr McCoy had indicated that the requested report could be used to appraise the Department of the problems the WHSSB was facing in providing childcare with a view to making the Department more amenable to requests for resources to deal with the problems.[106]

123 On 23 July 1990, SND 502 wrote to Dr McCoy and outlined the overall situation the WHSSB faced in relation to childcare and the investigation and action taken in relation to Harberton House.[107] She explained that, given the resource difficulties and pressures the workers in Harberton House were facing at the time of the incidents and their perceptions

103 FJH 10026.
104 FJH 10286.
105 FJH 11016.
106 FJH 10037.
107 FJH 10113.

that senior managers, and she in particular, did not understand their "impossible situation", it would not have helped staff morale or enhanced the safety of children for her to have undertaken an investigation of the incidents.[108] She also asked that "the ever increasing childcare difficulties should be looked at immediately with a view to the DHSS offering additional revenue". She suggested that such additional revenue could be used to appoint additional social work practitioners and to create a childcare team, a child protection team and a team of social workers working with children in residential care.[109]

124 This letter and its appendices were discussed by officials at a meeting in the Department on 26 July 1990, where it was agreed that the WHSSB should be asked to carry out an independent investigation which would:

- "review the background to the incidents and, in particular, why the incidents were not detected earlier;
- explore the lessons to be learned for the Province as a whole;
- examine the roles of individual staff including key workers and supervisors;
- review the training implications;
- explore the multi-disciplinary nature of the care and treatment requirements of the children involved."[110]

125 Mr Hunter, Chief Executive of the Department's Management Executive, contacted Mr Frawley, General Manager of the WHSSB, to request this investigation. Mr Frawley agreed to the investigation so that lessons could be learned and related training needs of social care and other professional staff could be identified. Mr Frawley agreed to ask SND 502 to liaise with Dr McCoy over who might undertake the investigation and agreed it should be done "in such a way as to avoid the appearance of a witch hunt and recriminations".[111]

126 On 31 July 1990 Dr McCoy met with SND 502 at Dundonald House and followed up that meeting with a letter offering draft terms of reference for the investigation, which included a specific focus on why the sexual activity between the children in Harberton House was not detected earlier and an examination of the roles and responsibilities and professional activities of staff responsible for supervision of the children in the relevant period.[112]

108 FJH 10118.
109 FJH 10119.
110 FJH 10995.
111 FJH 10994.
112 FJH 10992.

127 When Dr McCoy received a copy of the brief that had been given to the Review Team[113] he wrote to Mr Hunter to express his concern that the terms of reference for the review failed to make specific reference to the events in Harberton House and why the sexual activities were not detected sooner. He suggested that "the Board will use the review to emphasise their inadequate revenue basis" and that "the issues of supervision and management in Harberton House will not get the scrutiny they deserve."[114]

128 In response to Dr McCoy's concerns, Mr Hunter wrote to Mr Frawley on 30 August 1990 and indicated that while it was reasonable for the review to consider resource implications he would be concerned, "if the Team concentrated on this issue to the detriment of other factors surrounding the care of severely abused children".[115]

129 In a written statement to the Inquiry, Dr McCoy confirmed that his view remained that the emphasis in the terms of reference on the resources available to the Board generally was an attempt to extract more resources from the Department, he commented: "…it was opportunistic".[116]

The Review Process

130 The Review was chaired by Bob Bunting, Assistant Director of Social Services (Family and Child Care) Eastern Health and Social Services Board and he was assisted by Mr T Armstrong, Senior Social Services Manager WHSSB and Miss J Ross, Principal Social Worker (Training and Staff Development) WHSSB. The review team took the view that residential services for children could not be seen in isolation but had to be considered within the context of the total WHSSB's family and childcare programme. We consider this an appropriate approach since, as set out above, the number of emergency placements Harberton House had to deal with and the lack of foster placements to send children on to hampered its ability to fulfil its remit.

131 In considering the wider context in which the home operated the review team compared the social work resources of the Foyle Community Unit, the unit of management within the WHSSB in which Harberton House was located, with those of North and West Belfast, the unit closest to it in population size. The comparison showed that the staffing establishment

113 FJH 10987.
114 FJH 10986.
115 FJH 10984.
116 FJH 40886.

of the North and West Belfast unit's Family and Child Care Programme, which consisted of fifteen senior social workers and 53 social workers, meant it had nine more senior social workers and twenty more social workers than the Foyle Unit.[117]

132 The review team identified that the increased demand for childcare and the lack of resources to address it during 1989 and 1990 indicated "a high level of risk for children and staff in the Unit".[118] It referred to field social workers having to keep children in risk situations when they would have preferred them to be in care, and to residential staff being unable to undertake therapeutic work because of the number of children for whom they had to provide basic care. The team concluded that the extension of the range of services available, for example the provision of fee-earning foster parents, would provide advantages both in terms of efficiency and cost-effectiveness.

133 After making these general observations about the context within which Harberton House operated the review team considered how the home was run, including its admission and discharge records in the relevant period. It concluded that although the home was over-occupied in the relevant period, and this necessitated the employment of inexperienced staff who required training and support, the "main problem was the constant pressure of dealing with a highly disruptive and sexualised group of children".[119]

134 The review team considered the profile and current position of each of the eight children who had been identified as being involved in the sexual activity. They also included within their considerations the adolescent girl referred to above who had been interviewed by the police and admitted distracting staff in order to let the sexual activity take place. The review team stated that they were of the opinion that the adolescent children "were involved in the sexual activities though to what extent remains unclear".[120] They considered reviewing the other eight young people and looking at their records but decided not to as the police had decided not to interview them. Given the review team's suspicions about the involvement of adolescent children in the sexual activity we consider that it was a lost opportunity that they did not widen their review to consider any other recorded incidents of peer sexual activity in the home. This could have

117 FJH 20301.
118 FJH 20302.
119 FJH 20307.
120 FJH 20308.

identified other occasions, such as that involving HH 48, where sexual activity between three children was recognised as a recurring problem and where (at least on one occasion) it only came to the attention of the staff through one of the children involved making a disclosure about it.

135 The review team identified that only one of the nine children was understood to have been sexually abused prior to admission to care and another, an adolescent girl, was known to have previously had sexual intercourse with adolescent boys. The other seven children had been admitted to care because of behavioural problems and/or relationship problems with their parents or foster carers. However, through disclosure work while they were in Harberton House, prior to the uncovering of the peer sexual activity, the staff reached the view that all but two of the children had been sexually abused, had witnessed sexual activity or had been involved in sexual activity with other children prior to their admission to care.[121] Staff told the review team that they had received some relevant in-service training about caring for sexually abused children but were unable at times to apply this training due to the pressures they faced on a day-to-day basis.

136 The review team concluded that supervision of the children had been inadequate because of the low staff to resident ratio caused by the increased number of residents and the policy of staff having two days a week during the school term for report writing, liaison with families etc, which reduced their direct contact time with the children.

137 During the review process, the chair of the review team was copied into a memo that HH 22, the acting officer in charge wrote on behalf of Harberton House staff to Gabriel Carey on 1 November 1990.[122] In this memo, HH 22 pointed out that staff were continuing to have to deal with over-occupancy of the home leading to a dependence on inexperienced and unqualified staff, which was creating a similar set of circumstances to that which pertained at the time the peer sexual abuse occurred earlier in the year.

She placed on record the feeling of the staff group that:

> "… this present situation mitigates [sic] against fulfilling the Board's statutory responsibility to provide care, protection and control for children who require it."[123]

121 FJH 20342.
122 FJH 10084.
123 FJH 10084.

138 Mr Carey responded to the memo on 16 November 1990[124] and detailed the action that had been taken to raise resource issues with the Department and establish new social worker posts. He acknowledged the frustration of staff and indicated it was shared by all childcare managers but pointed out that managers, including HH 22, must provide leadership to help staff work through difficulties and provide the best standard of service possible to the children in their care.

139 In her oral evidence to the Inquiry, HH 22 said that she could not emphasise enough the impact that overcrowding had in Harberton House. She explained that staff felt they had no real say on admissions, because if a child needed to be cared for and there was nowhere else they could go they had to be admitted.[125]

The Review Team's Conclusions and Recommendations

140 The review team concluded that there were a number of important aspects which in combination created exceptional conditions within Harberton House that made it possible for the sexual abuse to continue undetected. They identified these aspects as:

- the number of children with sexualised behaviour in the home at the same time;
- the power exercised by two boys in particular and their intimidation of other children; and,
- the level of planning of sexual activity, including the distraction of staff and acting when staff cover was at a minimum.

The inadequate staff to child ratio was seen as a contributory factor in the relevant period but the review team made a more general point that the size of the home with two groups of twelve and thirteen children made it difficult to provide a satisfactory standard of care for the type of children and young people requiring residential care.

141 The review team assessed the performance of all residential and fieldwork practitioners as adequate, given the pressures they were under, the limits of their knowledge and awareness, and the resources available. In the case of residential staff, this conclusion was qualified as being in the context of the number of staff on duty to care for the total group of children. The point was made that, given the substantial group of very disturbed children

124 FJH 10081.
125 Day 127, p.91.

in the home, consideration should have been given to increasing the number of staff on duty. The performance of the management staff of the home and senior social workers was also deemed adequate; the review team found they were clear about the pressures staff were working under and informed middle and senior managers about them. The performance of middle and senior managers was also deemed adequate given the increasing demands and the resources available.[126]

142 The review team stated that the workloads of field social workers and the management span of control of senior social workers were not conducive to providing child protection of satisfactory quality and that it was unrealistic to expect the workload of the Assistant Principal Social Worker (Family and Child Care) to be carried by one person.

143 The concluding statement of the review report focused on the lack of resources:

> "The Unit of Management is under-resourced in relation to the amount, range, complexity and stressful nature of the Family and Child Care 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."[127]

144 Given this analysis, it is perhaps not surprising that the eighteen recommendations in the report of the review focused on the need for strategic development of childcare services and additional resources. The review team recommended an immediate review of the size and function of Harberton House with a view to reducing the residential care component and concentrating it into one unit. It also suggested that the physical space this would create 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. It recognised that the residential places that would be lost through such a development might still be required and recommended that if that was the case a further smaller residential facility should be developed.

145 In addition to recommendations about improving staff development and supervision, an immediate review of staffing levels and the duty rota in the two Board homes was recommended to ensure that there were sufficient

126 FJH 20337.
127 FJH 20354.

staff on duty to provide satisfactory care for the total group of children and allow time for individual work. A practical recommendation was made that the mound in the grounds of Harberton House should be levelled to facilitate the supervision of children.

WHSSB's Response to the Review Report

146 The review report was presented to the WHSSB Area Executive Team on 22 November 1990 and presented to the Community Care Committee of the WHSSB on 7 December 1990. Mr Bunting, the Chair of the review team, discussed his findings with Committee members. Mr Frawley, General Manager, cautioned the Committee that the recommendations were wide-ranging and could have serious resource implications and asked for the management team of the Foyle Community Unit to be given time to consider them.[128]

147 Mrs McGowan, the Committee member who made regular monitoring visits to the home, referred to the statement in the review report that "children and staff were still at risk". She urged serious consideration to be given to minimising the level of risk as a matter of priority.[129] However, the Committee agreed that senior managers should be given the opportunity to consider the recommendations and to report back to its next meeting.

148 Mr Frawley and HH 34 (Unit General Manager) attended the next meeting of the Community Care Committee on 1 February 1991 and the minutes of that meeting recorded that they provided committee members with an update on the measures that management and staff were taking to address "difficult aspects of caring for children".[130] The committee agreed that the Board should convey its concern about the need for additional funding to the Department. Mr Frawley undertook to write to the Department and while pointing out that it might consider the pressure on childcare as a national rather than local problem he said he would:

> "...put forward the case again for the Board's uniquely underfunded situation and ask the Department to consider the matter in the knowledge of the analysis they have sight of and consider making some exceptional arrangement for the Board."[131]

128 FJH 10432.
129 FJH 10432.
130 FJH 10436.
131 FJH 10437.

The chairman of the Community Care Committee is recorded as concluding the discussion by pointing out that while the Board had the responsibility to deal with the issues identified in the review report the Department, being a party to that report, also had a responsibility towards solving the problems.[132]

149 Mr Frawley wrote to Mr Hunter of the Department on 13 February 1991.[133] He explained that in light of the sort of investment that would be required to address the recommendations in the review report and the level of funding available to the Board compared to other Boards, particularly the Eastern Board, the Community Care Committee had asked him to ask the Department to consider making a separate allocation "to address this very worrying problem". He explained that the committee appreciated the difficult financial climate, but felt that "an issue of this complexity and public concern does need urgent attention". Mr Frawley finished his letter requesting a meeting to discuss this and more general matters relating to finance.

150 An internal memorandum from a civil servant Mr Green entitled "*Review Of Child Care Services*"[134] recorded the outcome of a meeting Mr Green, Dr McCoy, Mr Kearney and Mr Hunter had with Mr Frawley and Mr Burke on 27 February 1991. Mr Frawley was recorded as telling the officials that the Chairman of the WHSSB remained extremely unhappy about the Board's funding deficit and considered that the DHSS had not done enough to address it in the allocations for the next financial year. Mr Frawley advised that the matter was likely to come to a head at the forthcoming Policy and Resources Committee meeting when:

> "…the need for additional resources for the development of Child Care Services will be on the agenda and the disparities in staffing levels and other resources between the Western and Eastern Boards will be highlighted".[135]

Mr Green recorded the explanations he provided about why the funding arrangements could not be improved immediately, including that the DHSS held no reserves, and pointed out that £300,000 had already been skewed to the WHSSB despite the DHSS's limited ability to allocate additional funding. He also provided assurances about the DHSS's commitment to introducing a full capitation based funding position. Despite these assurances Mr Frawley requested an urgent meeting with Mr Hunter.

132 FJH 10437.
133 FJH 10979.
134 FJH 50740-41.
135 FJH 50740.

151 This meeting took place on 6 March 1991 and Mr Hunter's memorandum to Mr Green about it confirmed that Mr Frawley had raised the WHSSB's need for additional resources for the development of childcare services as well as broader issues about the funding available to the Board. Mr Hunter recorded that he had provided the same explanations and assurances as Mr Green had previously offered to Mr Frawley and offered some hope that additional funds might be available in 1992/93 that the Board could use to develop its child care services. However he recorded that he made clear to Mr Frawley that in the meanwhile:

> "...it was the Board's responsibility to manage any problems which currently exist in respect of the delivery of these services."[136]

152 Mr Frawley subsequently wrote to Mr Hunter on 20 March 1991 to record the WHSSB's Resource Allocation Committee displeasure at what it perceived as "positive discrimination by the Department against this Board in properly addressing the issue of equity in resource allocation". He went on to state that "Board members felt that their position and that of the Board in relation to both staff and children was becoming untenable".[137] Mr Hunter provided a written statement to the Inquiry in which he said he did not recall meetings he may have had with Mr Frawley and that as far as he could remember the WHSSB never argued through its area and operational planning process that it was under-funded for a particular service.[138] As indicated previously we consider the WHSSB's funding situation more generally in the section dealing with Finance in Volume 1. However, in relation to responding to the particular funding issues raised by the Bunting Review we consider that the WHSSB, through its senior officials, persisted in trying to attract funding to improve its child care services and made clear that its position in relation to both staff and children was becoming untenable.

153 While these discussions were taking place Dominic Burke wrote to Dr McCoy on 27 February 1991 to inform him of the action the WHSSB had taken to meet the recommendations of the Bunting Review including allocating £35,000 to fund increased staffing in Harberton House and £39,000 to increase foster care. He indicated that he would provide Dr McCoy with the minutes of the Community Care Committee's discussion of the review and share with him the Foyle Unit of Management's response to the

136 FJH 50742.
137 FJH 50742.
138 GOV 629.

recommendations of the review and the resources it considered necessary to implement them. Mr Burke also referred to the discussion Mr Frawley and he had with Dr Mc Coy and his colleagues on 26 February 1991 about efforts being made to redress the resourcing issues in the Board's Operational Plans and stated he would share the outcome of current discussions on the Plans with Dr McCoy as soon as possible. He reminded Dr McCoy that it was recognised at the meeting that:

> "…these efforts because of other competing demands fail to meet the requirements as we explained additional resources will be required to meet this shortfall".[139]

154 In that context, he asked for additional funding of £130,000 to develop an assessment and treatment unit at Harberton (the inference was that this would be for peer abusers) and suggested that the provision of this funding from the Department would be "a recognition of this Board's difficulties and our joint efforts in redressing the resource problems".[140] He finished his letter by informing Dr McCoy that the Board was still experiencing sustained pressure within its childcare services. He explained that despite the increase in fostering provision Harberton House continued to be full and the staff bungalow was having to be used to accommodate children.

155 On 12 March 1991 Dr McCoy wrote to two of his staff, Mr Mc Elfatrick and Mr O Brien, copied to Mr Greene and Mr Kearney of the Child Care and Social Policy Division and provided them with a copy of Mr Burke's letter. He asked for a general discussion about what further action the Management Executive/DHSS needed to take and a specific discussion about Mr Burke's proposal for an Assessment and Treatment Unit.[141] Mr Kearney responded to this minute and informed Dr McCoy that he had no money to offer towards the suggested Assessment and Treatment Unit. He explained that he had put forward a Public Expenditure Survey (PES) bid for funds to address child sexual abuse covering prevention, protection and treatment (for victim and abuser). However, he pointed out that even if the bid succeeded resources would not be available until 1992.[142]

156 On 28 March 1991 Dr McCoy met with his colleagues Mr Simpson, Mr Kearney, Mr McElfratrick and Mr O'Brien to discuss the WHSSB's ongoing work to meet the recommendations of the review. They noted that the

139 FJH 587.
140 FJH 588.
141 FJH 16347.
142 FJH 16346.

WHSSB was meeting on that day to discuss resource allocation proposals for 1991/2 which included:

- £35,000 to improve childcare services generally in Foyle Community Unit
- £30,000 to provide greater support to existing foster placements
- £45,600 to Nazareth House children's home
- Additional funds to employ two house parents in Coneywarren home to bring the staffing levels up to those set down in Castle Priory guidelines
- £90,000 to establish child and adolescent psychiatry services for the area.

There was no reference in the note of the meeting to Mr Frawley's letter to Mr Hunter, which had been copied to Dr McCoy and which had requested additional discrete funds to address the recommendations of the review, to the meeting Dr Mc Coy attended with Mr Frawley and Mr Burke or to Mr Burke's written request to Dr McCoy for additional funds to establish an assessment and treatment unit. The meeting concluded that no direct action was required by the Department at that time. It was noted that the WHSSB was continuing discussions with the Foyle Unit of Management about their responses to the conclusions and recommendations contained in the Bunting review and that a report of these discussions would be submitted in due course. It was agreed that the WHSSB's implementation of its operational plan would be monitored, staffing levels in children's homes in the four Boards would continue to be monitored and discussions would continue with Board staff about the extent of peer abuse among children.[143]

157 As part of the Warning Letter process the DoH pointed out that the information provided in Mr Burke's letter of 27 February 1991 that the WHSSB was allocating £35,000 to meet increased staffing needs in Harberton House and £39,000 for extra Boarded-out payments and appointing additional field social work posts made it appear to the DHSS that the immediate pressures on Harberton House had been responded to quickly and appropriately by the WHSSB. The DoH also commented on Mr Burke's reference to the discussion in the meeting Mr Frawley and he had with Dr McCoy and representatives from the DHSS Management

143 FJH 16344.

Executive in February 1991 about attempts to redress the under resourcing issues in the Board's Operational Plans. The DoH suggested that this reference indicated that the DHSS Management Executive had asked the WHSSB to address under-resourcing issues in its operational plan and was sympathetic to the WHSSB's request for additional finances to make up the shortfall in other services (ie "competing demands") which had been created by the alleviation of the Harberton House situation. We found no reference in the minute of that meeting[144] to the DHSS asking the WHSSB to address under-resourcing issues in its operational plan and we understood from Mr Burke's letter that he was saying the efforts taken to address the requirements of the Bunting review were insufficient because of other competing demands and that additional resources were required.

158 It was also agreed in the meeting of 28 March 1991 that Mr Kearney would ask Dr Kilgore to monitor the establishment of the Child and Adolescent Psychiatry Service which was contained in the WHSSB's Development proposals for 1991/1992. Mr Kearney subsequently wrote to Dr Kilgore on 8 April 1991 to point out that although it was not possible to provide funding for an assessment and treatment unit it should be possible for the WHSSB 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 which the WHSSB intended to recruit. He went on to ask Dr Kilgore to highlight the importance of this work in any contact with the consultant once he/she was appointed. Mr Kearney finished by asking that he and Dr Kilgore stay in touch with developments in establishing the service to ensure that maximum use is made of it for child protection purposes.[145] There is no indication that this helpful intervention was shared with Mr Burke.

159 We noted that Mr O'Brien who attended this meeting had recently completed an inspection of Harberton House on the week beginning 11 February 1991. He made a number of observations and recommendations in his report of that inspection in response to the circumstances he found in the home, which were strikingly similar to those that the review team had concluded had aligned to create an environment in which the peer sexual activity in Harberton House in late 1989 and early 1990 had gone on for so long without detection.[146] These included:

144 FJH 50740-50741.
145 FJH 16342.
146 FJH 16513–16564.

(1) The number of children living in Harberton House had exceeded the places provided in the home for some months and this situation was pertaining at the time of the inspection.[147]

(2) Although the staff bungalow was being used to accommodate children, the demand for residential care was such that children had to be diverted to other statutory and voluntary homes.[148]

(3) In the circumstances, Harberton was incapable of providing a reception/assessment service for all children coming into the Board's care. The home had been reasonably successful in discharging children within twelve months of placement, thereby retaining the short/medium term nature of the facility and its main aim could have been attained if there had not been such a surge of admissions to the facility in the months preceding the inspection.[149]

(4) Staff ratios should be revised to allow staff sufficient time for primary duties and group care of children.[150]

(5) Less than half of the staff had been to short training courses on appropriate topics and "this was disappointing though, in circumstances where the home was over full and going through a difficult period understandable."[151]

(6) At best, staff were receiving supervision every two months when the expectation was that they should receive it every two weeks and at least once a month.[152]

(7) Staff were striving to implement programmes of care for individual children but the time taken had become protracted in some cases because of the number of children.[153]

(8) The officer in charge had informed him that Harberton was still catering for a considerable number of children who had sexual experience inappropriate to their chronological ages.[154]

160 Mr O'Brien quoted Mrs McGowan's conclusion that the Board "was failing in its duty to protect children".[155] He also quoted the review team's

147 FJH 16522.
148 FJH 16522.
149 FJH 16522.
150 FJH 16532.
151 FJH 16530.
152 FJH 16534.
153 FJH 16546.
154 FJH 16538.
155 FJH 16550.

recommendation that there should be an immediate review of the size and future of the home and its suggestion of the establishment of a multi-disciplinary team to undertake assessments of sexually abused children. He concluded that it appeared an appropriate time to review the procedures for admitting children to the home, revise its overall capacity and to reconsider its management structure and staffing levels.[156]

161 There is no record that Mr O'Brien's conclusions from this inspection informed the discussions he had with Dr McCoy and other colleagues on 28 March 1991 about the provision of childcare services in Harberton House. On 24 January 1992, Dr McCoy sent a letter to Mr Frawley expressing concern that reports of SSI inspections of children's homes in the Western Board's area had been issued to the appropriate unit of management and to the Nazareth Order in relation to Nazareth House, but that formal responses to the reports and the recommendations contained within them, had not been received.[157] Dr McCoy enclosed an overview report on the SSI's findings from these inspections and in his letter highlighted issues from them which required attention. Therefore, it appears that almost a year after the inspection of Harberton House the SSI was awaiting responses to the significant recommendations contained in the report of that inspection.[158]

162 Mr Frawley responded to Dr McCoy's letter on 27 April 1992. He confirmed that responses to the inspection reports had now been sent. We noted that he also referred Dr McCoy to a detailed report that was recently sent to him about a review of the WHSSB's implementations of the recommendations arising from the Bunting Review. Mr Frawley also pointed out that Dr McCoy would be aware from the Board's Annual Monitoring Reports for 1990/91 that the significant demand for care places meant the Board had to take a managed approach between the need to provide care and protection for children who were at risk in the community and meeting the objectives of individual units. Therefore, although responses to inspection reports had not been received we accept that there were other ways in which the WHSSB was accounting for its performance to the SSI.

163 We noted that the WHSSB's Social Care Committee considered the recommendation of the report of the inspection of Harberton carried out

156 FJH 16562.
157 HIA 5822-3.
158 FJH 50734.

in February 1991 when it met on 8 April 1992.[159] The minutes of that meeting recorded Mr Haverty informing the Committee about action taken to address certain recommendations including the need to ensure regular supervision of staff and review the staff rota to enable more staff contact with children. However, there was no record of any discussion about the points raised by the inspectors about Harberton continuing to have to accommodate more children than it had places for, the staff bungalow being used to accommodate children and the home consequently not being able to meet its remit as an assessment centre. While we recognise that these matters may have been discussed but not put on the public record of the meeting, on the basis of the evidence before us it appears that the Committee did not address these significant resource and strategic issues.

164 With regard to Mr Burke's letter of 27 February 1991 requesting additional funding, it appears from an annotation on the letter that it was received on 7 March 1991. Dr McCoy's written response was over ten months later on 20 January 1992.[160] Dr Mc Coy and Mr Burke told us when they gave oral evidence that a good relationship existed between the SSI officials and WHSSB managers and that informal advice was sought and offered, so it may be that there was informal contact between these officials during the period that elapsed between letters. However, we considered that a ten month delay in providing a formal response to a letter that was seeking assistance to address serious problems was not good practice.

165 In his response, Dr McCoy referred to Mr Burke's request for £130,000 to establish an assessment treatment centre at Harberton House and acknowledged that Mr Burke had sought his support for this funding application. He asked Mr Burke to let him know what stage the proposal was at and whether the Board had been able to allocate funding for it.

166 Mr Burke responded on 7 April 1992. He provided Dr McCoy with an update on the steps the Board had taken to implement the recommendations of the review team, including strengthening social worker and family aide resources and increasing fostering provision. In relation to Harberton House he informed Dr McCoy that a review of the structure of the three children's homes in the Area had been undertaken and that the intention in relation to Harberton House was to revise the staffing structure and

159 FJH 50738.
160 FJH 590.

reduce the occupancy level to twenty. He explained that on the basis of this proposal, consideration was being given to the establishment of a separate small unit to cater for four or five children displaying particularly disturbed behaviour, including those who had been sexually abused and/or had been sexually abusive. He indicated that Dr McCoy would be aware of the WHSSB's plans to reduce the number of residential places on a progressive basis. We took this to be a reference to Dr McCoy's awareness of WHSSB's Strategic Plan in which these intentions were set out.

167 Mr Burke did not specifically respond to Dr McCoy's question about the funding for the assessment treatment centre. Although he indicated that there would be costs associated with reducing the number of residential places he did not give an indication of the level of costs or ask for any additional funding.[161] When he gave evidence in person during Module 5, Mr Burke confirmed that it took about another ten years for an eight-bed assessment unit and emergency admission centre to be opened and that it did not open until after the closure of Fort James, Termonbacca and the Nazareth House children's home in Bishop Street.[162]

168 Dr McCoy responded to Mr Burke on 15 May 1992. He noted that the WHSSB had not been able to implement all of the recommendations of the review report because of competing demands but commented:

> "The Board is to be commended for the comprehensive range of measures introduced following this most thorough scrutiny of its services."

He went on to identify three areas of continuing concern: unqualified staff continued to be recruited in Harberton House; only three out of the eight additional social worker posts recommended by the review had been established; and, the span of control of the Assistant Principal Social Worker had not been addressed. He made no further mention of whether funding was required for the proposed treatment and assessment centre.[163] Mr Burke acknowledged Dr McCoy's letter on 21 May 1992 but did not make any further requests for funding.[164]

169 We consider that the Department, and Dr McCoy in particular, demonstrated a proper concern that the circumstances of the co-ordinated peer sexual

161 FJH 592-598.
162 Page 51, Day 125.
163 FJH 10371-2.
164 FJH 10370.

abuse in Harberton House should be fully investigated and lessons learnt and shared with other Boards. However, we consider that the SSI should have engaged more fully and immediately with the WHSSB's request for additional funding to strengthen its childcare services, even if funding constraints meant that assistance had to be limited to helping it to consider how its existing resources could be put to most effective use. We accept as pointed out by the DoH that the DHSS was not in the position to respond to the request for £130,000 for the assessment and treatment unit in the absence of properly costed proposals and operational plans. However, we saw no evidence that the DHSS or SSI on its behalf asked for this information. We found it particularly concerning that the SSI's decision to maintain a watching brief on the WHSSB's implementation of the Bunting recommendations was taken shortly after an inspector identified circumstances in Harberton House very similar to those that pertained at the time the co-ordinated peer sexual abuse occurred. The DoH pointed out that the suggestion in the Bunting report that an adolescent support centre could be established was linked to a recommended review of the residential component in Harberton House and that clearly that review needed to take place in the first instance. While we accept this point we could find no evidence that it was made at the time to Mr Burke when he requested the funding for the unit**.**

170 We are clear that the WHSSB was responsible for ensuring that it allocated the funding available to it in a manner that ensured its services for children were sufficient to enable it to discharge its statutory obligations and that it was also responsible for the management and quality assurance of its child care services. We accept that the DHSS was not in the position to immediately provide additional funding and that in any case the establishment of an adolescent treatment centre had to be considered within a wider review of the residential capacity of Harberton House. However, we saw no evidence of SSI engaging with the WHSSB to support it to consider how best to implement the recommendations in the Bunting review including, but not solely, the financial implications of doing so. This was despite the fact that the SSI was aware that adverse conditions were continuing to affect the care that children were receiving in Harberton House. **We consider this lack of engagement amounted to a systemic failing to ensure the home provided proper care.**

171 The WHSSB and the Department worked together to organise a seminar for providers of residential care in Northern Ireland about the risks of peer

abuse in residential care, which was held in February 1992. Mr Kearney of the Department made a presentation on the work he had undertaken to monitor the extent to which children in Northern Ireland were known to have been sexually abused prior to admission into care and the extent of known peer abuse within residential homes for children.

172 The Department included a requirement in the 1992-1997 Northern Ireland Regional Strategy for Health and Personal Social Services for Boards to start work to secure, in the longer term, access to evaluated treatment programmes for child and adolescent abusers aimed at containing and, if possible, reducing such behaviour. In addition, the Regional Strategy recognised the need for Boards to move away from multi-purpose children's homes to a range of small specialist units designed to meet clearly identified needs.

Further Incidents of Peer Abuse in Harberton House

173 The review team's identification of continued risk to children and staff in Harberton House was realised in May 1992 when further incidents of peer sexual abuse were identified in the home.[165] On this occasion an adolescent female resident told a member of staff that she had heard three younger male residents discussing sexual matters. When staff interviewed the boys it became clear that one of the boys aged eight years had threatened the other two boys aged seven years and intimidated them into simulating sexual intercourse, while fully clothed, while he observed them.

174 This activity had not gone undetected for a prolonged period of time; it was described as having happened "over the past few weeks".[166] However, we noted that it was only brought to the attention of staff by another resident, and the activity took place at the same time as in the previous incidents, i.e. early in the morning and after school when staff were involved in hand-over meetings. The use of waking night staff, which had been introduced as a result of the previous incidents of peer sexual abuse in the home, had been discontinued at the end of October 1991. In response to this new incident, sleeping-in staff were increased to two in the medium stay unit, one of whom commenced work at 6am to supervise the children. Mr Carey asked senior managers to support a longer term measure of employing staff at care assistant level to act as waking night staff.

165 FJH 15536.
166 FJH 15481.

175 In 1992 the capacity of the home was reduced to twenty places, ten in each unit. However, the staff and children continued to have to deal with the impact of over-occupancy at times when the number of children requiring care was in excess of available places. For example, when Ruth Lavery visited the home, on 14 July 1993, she completed the pro-forma used by the visiting committee and recorded the concerns of staff that:

> "Numbers of children were regularly over the upper limit [because of] crisis interventions and limited fostering resources. Inability to develop specialist work with abused (& abusing children) because of general demands."[167]

176 Further incidents of peer sexual abuse came to light in April 1994 when staff investigated an incident that occurred on 25 April 1994 when a boy then aged eleven years, SPT 81, and another male resident exposed themselves to each other. During this investigation information emerged that SPT 81 and two other male residents aged seven and thirteen years had been sexually assaulting a female resident in the home for prolonged periods over a number of months. While this matter was being dealt with, a further incident of SPT 81 being involved in sexual activity with another boy was detected by domestic staff on 20 June 1994. SPT 81 was subsequently transferred to St Patrick's training school on a Place of Safety Order on 22 July 1994 and sadly was killed in 1994.

177 In response to SPT 81's death, the WHSSB established a team to review the care he received. Bob Bunting who had chaired the earlier review into the peer sexual abuse in Harberton House also chaired this review. In relation to the care SPT 81 received in Harberton House the review team concluded that the fact that the abuse of the girl in Harberton House by SPT 81 and two other boys went undetected, and that SPT 81 was able to intimidate the girl once the abuse came to the attention of staff, raised questions about the adequacy of supervision in the home.[168] The review team also questioned whether there was sufficient contact time between staff and children to allow necessary therapeutic work,[169] and concluded that the habitual use of 'time out' with SPT 81, 46 occasions in a four-month-period, made it an ineffective means of dealing with his behaviour.

167 FJH 17159
168 SPT 19032.
169 SPT 19047.

178 The review team also concluded that the homosexual activity between SPT 81 and another boy in June 1994 was serious and suggested knowledge of homosexual intercourse which should have been reported to the police so that they could have investigated how the boys had gained such knowledge and whether either of them had been sexually abused.[170]

179 The review team recommended that the standards of supervision of the children should be improved in Harberton House and that staff rotas should be revised in order to increase contact time with children.[171] There was no reference in the report to the previous review of incidents of co-ordinated peer sexual abuse in Harberton House or that similar recommendations had been made as part of that review.

180 It was clear from the evidence we considered that although Harberton House was designed to provide focused short-term assessment of children's needs and some emergency beds, it was not able to meet its planned remit from soon after it opened. This was because the level of demand for residential care for children meant it had to accept a large number of emergency placements. Also, the lack of alternative residential care and fostering resources meant children could not be moved to appropriate services once their needs were assessed and care plans agreed. HH 5 reported to Mr Carey that this resulted in some children feeling frustrated and hopeless and led to behavioural and disciplinary problems.[172] We consider that it was also likely to have meant that children whose care needs required to be assessed could not benefit from the services in Harberton House because places were not available as they were filled by emergency placements and children waiting for alternative appropriate placements.

181 At around the same time as Harberton House opened, it was decided that Fort James should focus on the care of older children. This decision had significant implications for the provision of medium to long-term care for younger children. We understand the view expressed by Mr Carroll at that time that residential care was not an appropriate choice for children under school years but, as he recognised, such an approach could only be sustained if there were sufficient and appropriate foster placements to accommodate such children.[173] This was not the case, and was known

170 SPT 19052.
171 SPT 19055.
172 FJH 40020.
173 FJH 6555.

not to be the case, and it meant that achievement of the stated remits of Fort James and Harberton House was undermined by the need to accommodate younger children, often in emergency circumstances. A clear example of the impact of this lack of provision was the placement in 1990 of four children all aged less than six years of age in the staff bungalow in Harberton under the care of a new team of inexperienced staff.

182 From the evidence we have considered, we have concluded that the WHSSB's strategic planning of Harberton House did not take proper account of the need to ensure that complementary services were in place that would allow its remit as an assessment centre to be realised and protected. The HSCB accepted in its response to the Warning Letter process that that while there was a strong desire to use Harberton House as it was originally intended in reality the frustration of large numbers of admissions along with inadequate resources for alternatives made this very difficult. We consider that this failure in strategic planning contributed to inappropriate placements of children in the home and children remaining in the home after the assessment of their care needs had been completed. We also consider that the pressures this placed on staff contributed to the inadequate supervision of children and lack of therapeutic work with them that enabled the co-ordinated peer sexual activity in Harberton House in 1989-1990 to continue undetected for as long as it did. **We consider this failing in strategic planning amounted to a systemic failing by the WHSSB to ensure that Harberton House could meet its intended remit and provide proper care.**

183 When Dr Harrison gave evidence in person on behalf of the DHSSPS she told us that although the Department did not give capital funding to Boards, Boards were required to submit plans for children's homes through the Department so that it could scrutinise the proposed purpose, function, location, structure and size of the home and its feasibility. She recalled that questions would usually go back and forward between the Department and Board about proposed plans and that the plans would only be put forward as part of a public expenditure bid when the Department was satisfied with them.[174] Dr Harrison explained that since the final bid had to have the Department's approval it was expected that any elements the Department wished a Board to address in relation to a proposed home

174 Day 129, p.22.

would be incorporated in the final bid.[175] Dr Harrison could only speak from personal experience about the Department's process for scrutinising plans in the 1990s. She confirmed that at that time the scrutiny would have included how a proposed home would fit within a Board's wider childcare services, for example fostering provision.

184 Further to this evidence, we put additional questions in writing to the DHSSPS about the involvement of the Department in the consideration of the plans for Harberton House. Dr Harrison responded in writing on behalf of the DHSSPS and informed us that it had not been possible to locate any records about the Department's consideration of the proposal to establish Harberton House. However, she outlined the standard procedures which the Department used at that time to consider such proposals and confirmed that the DHSSPS had no reason to believe that these procedures were not followed in relation to Harberton House.[176]

185 Dr Harrison explained that a Board's proposals for the development of a children's home had to include the level of existing provision, the extent of the need identified, the type of service to be provided in the facility, the physical provision required and the proposed staffing level and structure.

186 The case put forward by the Board would then be considered by the Department's officials and professional advisors. Dr Harrison confirmed that professional advisors would have commented on the specifics of submissions in terms of standards of accommodation, numbers of children and staffing arrangements etc and that since they had an overview of existing statutory and voluntary children's home provision within the region:

> "...their views on the need for new provision would, of necessity, have had to take account of existing and projected numeric provision, as well as qualitative inadequacies or gaps in services and how the proposed home might address these or complement other necessary developments in child care services."[177]

187 In relation to the establishment of Harberton House, Dr Harrison told us it was unlikely that due regard would not have been given by the Department to the robustness of the WHSSB's plans to avoid children remaining in the home longer than necessary.

> "Part of this consideration would had to have been the extent to which

175 Day 129, p.24.
176 FJH 80002.
177 FJH 80003.

other services were in place to enable children to be assessed and moved in a timely manner to appropriate longer term placements. Also whether these services and (in the case of children who were to return home) family support services, were sufficiently adequate to support the proper functioning of a residential assessment unit within the Board's continuum of services."[178]

188 We found it surprising that given this level of scrutiny the lack of fostering resources and the growth in the number of children requiring care (increasingly on an emergency basis) were not identified and addressed as part of the consideration of the proposals to establish Harberton House. The lack of records meant we did not have access to the detail of the Department's scrutiny of the plans for Harberton House, including what time lag there was between funding for the home being agreed and the home opening. Clearly, if the time lag was significant then the demand for residential childcare and foster places may have increased in the intervening period. The lack of records also meant that we did not know if the Department gave any advice or guidance to the WHSSB about the establishment and operation of the assessment centre. Therefore, we are not in the position to reach any conclusions about the Department's role in approving the plans for Harberton House. However, the fact that almost from the point of opening, Harberton House was unable to operate as an assessment centre made us question the rigour of the scrutiny process.

189 The level of internal monitoring and governance of Harberton House was high, and those involved in it accurately identified pressure points and how they were affecting the quality of the care provided to the children. However, this awareness did not translate into appropriate and effective remedial action. We concluded that the time and energy invested in monitoring Harberton House was only marginally effective in its ability to positively influence the nature and quality of the service being provided. The wider context of the increased need for children to be accommodated outside their families and the lack of specialist residential services and fostering resources meant that although problems in, for example, the throughput of children, could be clearly identified, solutions were less forthcoming. We did not consider this was because of lack of commitment or concern on the part of staff and their managers. It was clear from contemporaneous documentation and from the evidence we heard from former staff and managers that they were committed to providing high quality childcare and felt frustrated and

178 FJH 80003.

hampered by the lack of appropriate resources and reported the impact of this to senior managers and visiting committee members.

190 However, we noted that at the same time as Harberton House and Fort James were under pressure to accept and work as best they could with more children than they were equipped to deal with, the WHSSB's Strategic Plan for childcare for 1992-97[179] set the objective to move to the position where no more that 15% of the children in its care should be in residential facilities by 1997.[180] This objective was in line with the 1992-1997 DHSS regional strategic plan, which required Boards to:

> "...seek to reduce the need for residential care and, with the development of preventive and foster care services as alternatives to residential care to reduce the stock of residential provision".[181]

In order to measure progress against this objective, Boards were asked to aim by 1997 to have at least 75% of the children in their care, excluding any children home on trial, in a family placement.[182]

191 The WHSSB set a more ambitious objective of moving to a position where no more than 15% of the children in its care were accommodated in residential care facilities by 1997. The Strategic Plan stated that as of September 1991, 91 children, approximately 18% of the 506 children in the care of the Board were accommodated in residential care. The target set was to reduce this number to a maximum of 58 places over the planning period, which meant that the WHSSB was going further than the Department's objectives.

192 The WHSSB recognised that it needed to improve its fostering provision significantly to achieve this change. It also considered at the time whether it should convert its children's homes to provide smaller units, each of which would enable specialised individual work with children in care that could not easily be undertaken in multi-purpose units.[183]

193 We recognised that the WHSSB was seeking to improve the appropriateness and effectiveness of its childcare services and to meet the Department's objectives in this regard, and that in the absence of additional funding new services could only be developed through releasing funding from existing services. However, we considered there was a striking mismatch at this

179 FJH 1005-1015.
180 FJH 1011.
181 FJH 80143.
182 FJH 80145.
183 FJH 1012.

time between the targets being set for reducing residential childcare places and the increasing demand for such places that field and residential managers and staff were struggling hard to meet. We will return to the general issue of the funding of the WHSSB in the section about Finance in Volume 1.

194 Also, while the Department's aspiration for Boards to develop preventative and foster services, and thereby reduce the need for residential care for children, was laudable, there seemed to be little recognition of the knowledge, gained through the SSI's inspections of the WHSSB's children's homes, of what a major task the WHSSB faced in achieving such a major shift of resources. When the WHSSB decided to reduce its residential childcare places through the closure of Fort James in 1995, the SSI, appropriately in our view, was concerned about the impact this would have on Harberton House and advised caution and reconsideration of the planned closure. The WHSSB continued with the closure but explained in response to the SSI's concerns that in the short-term eight additional residential places would be provided in Harberton House.[184] The SSI strongly, but unsuccessfully, advised against this interim compensatory measure because of the adverse effect it was likely to have on the management of Harberton House and the associated risks to children in the Board's care.[185]

195 We do not underestimate the challenges that the WHSSB faced in dealing with significant increases in the number and complexity of childcare cases while serving a community coping with high levels of deprivation, unemployment and social unrest. For example, contemporaneous documents record that the number of child protection cases in the Londonderry, Limavady and Strabane Unit of Management increased from 31 December 1982, where twelve children from six families were on the child protection register, to 31 December 1988, where 106 children from 44 families were on the register. It was also recorded that in the same Unit of Management there were 22 referrals about sexual abuse of children in the period 1 July 1985 to 1 July 1986, and this had increased to 100 such referrals by the period 1 July 1988 to May 1989.[186] Middle managers consistently reported on the pressures within residential childcare services and the associated impact on the quality and

184 FJH 40056.
185 FJH 40054.
186 FJH 10655-10662.

safety of the care that could be provided to children. Nonetheless, they recognised, as do we, that where children were in urgent need of care and protection some arrangement had to be made to accommodate them, however much that might compromise the limited resources available.

196 Immediately after the events in Harberton came to light the WHSSB allocated additional resources to increase staffing in Harberton House and increase fostering provision. It also considered the training needs of staff including the introduction of individual training needs profiles[187] and the need for the full range of child care staff to receive training in the development of skills in therapeutic work with victims of abuse.[188] Dominic Burke, in his letter of 7 April 1992, assured Dr McCoy that the WHSSB was continuing to develop its assessment of need strategies in relation to family and child care, was making good progress in related strategic planning and was undertaking a review of its three residential childcare homes. He also detailed planned further resource allocations to family and childcare programmes.[189] However, he reiterated the point he made to Dr McCoy in the letter he sent him in February 1991 that the WHSSB was experiencing difficulty in addressing all the recommendations of the Bunting Review because of the competing demands on resources.[190]

197 It is clear that while the WHSSB was seeking to implement the recommendations of the Bunting Review and address the Department's strategic objectives for childcare, managers and staff continued to struggle to provide appropriate residential care for children and the decision to close Fort James created further pressure. We consider a fundamental review of childcare services and residential care as part of those services was necessary at this time to protect the wellbeing and safety of children and that aspirational planning against a background of struggling and inadequate services was not appropriate.

198 Committee member, Ms McGowan's recorded views were that the Board was failing in its duty to protect children[191] and that urgent consideration needed to be given to minimising the continuing risk to children and staff identified by the Bunting Review.[192] Although senior managers sought to reassure Ms Mc Gowan about what action was being taken to deal with the

187 FJH 10149.
188 FJH 10151.
189 FJH 592-598.
190 FJH 592.
191 FJH 10011.
192 FJH 10432.

circumstances she had highlighted we saw no evidence of the Board itself specifically responding to these concerns or increasing its scrutiny of the ongoing quality and safety of its children's homes. As part of the Warning Letter process the HSCB pointed out that the Bunting review addressed issues about related services which impacted on residential care services. We accept this was the case and have indicated earlier in this chapter that we considered that was the right approach. However, our view remains that while the WHSSB made considerable efforts to address the pressures and issues highlighted in the Bunting review and engaged with the DHSS about them it did not undertake the fundamental review of its total childcare services that would have been necessary to address the fundamental problems it was experiencing in the delivery of its child care services and in particular in the provision of residential child care as part of those services. **We consider the WHSSB failed to instigate a fundamental review of its childcare services despite the findings of the Bunting Review and failed to increase its scrutiny of its children's homes in response to Ms McGowan's concerns and that these failings amounted to a systemic failing to ensure the homes provided proper care.**

Evidence from HIA 233 about her time in Harberton House

199 HIA 233 was placed in Harberton House on 28 October 1982 following the breakdown of a foster placement. She told the Inquiry that whilst she was in Harberton House a member of staff called HH 15 would grab her by the neck and "batter" her and that he abused her younger sister and other residents in a similar manner.[193] She alleged that the officer in charge of the home HH 5 knew HH 15 treated her in this way and did nothing about it. HH 5 strongly refuted this allegation in his second witness statement submitted to the Inquiry in Module 1, dated 10 March 2014[194] and continued to do so in his oral evidence to the Inquiry in Module 5.

200 In Module 1, the HSCB confirmed to the Inquiry that HH 15's personnel file had been checked and there was nothing in his file concerning any complaints about his behaviour or disciplinary action. However, we noted that documentation provided by the HSCB in relation to Harberton House included references to a complaint by a resident in 1989 about physical abuse by HH 15 which was investigated by a principal social worker and

193 FJH 008.
194 FJH 056.

assistant principal social worker who determined the complaint was not founded. There was also a record of a complaint from SPT 81 in June 1993 that HH 15 lifted him by the collar and threw him into a room thereby hurting his neck. It was recorded that this complaint was investigated by TL 4, Assistant Principal Social Worker, who did not find it possible to find any supporting evidence to substantiate SPT 81's complaint.[195] A further complaint was made by a resident in December 1994 that HH 15 had been rude to her on two occasions. It was recorded that HH 5 investigated the complaint and found no breach of professional practice.[196]

201 When giving evidence in Module 5, HH 5 confirmed that he had no concerns about HH 15's professional practice but pointed out that there was a problem, in that men (and particularly HH 15 because he was a man of considerable stature) were often used to defuse situations with children who were acting out in a physical manner. HH 5 was of the view that this approach made these male members of staff vulnerable. He stated that it was not until the mid-1990s that staff received appropriate training about managing and dealing with very challenging behaviour.[197]

202 HIA 233 also told us she was raped by a boy in Harberton House when she was about thirteen, and that she told another resident about what happened and that girl reported it to a member of staff, HH 20. HIA 233 said that when HH 22, who was then head of the long-stay unit in Harberton was told about the matter, she said to her: "are we back with these lies again HIA 233", and told her she was going to end up in a training school. HIA 233 told us that "Harberton" wanted her to report the matter to the police and she wanted to, but that nothing happened and she was not interviewed by the police.[198]

203 HH 22 gave evidence in person during Module 5 and was questioned about how she responded to HIA 233's disclosure about sexual activity with HH 18. HH 22 denied that she responded in the manner described by HIA 233. She told us that as a manager in the home her role would have been to see that policy and procedures were being followed rather than interviewing the children involved. She added that if she had made any reference to HIA 233 going to a training school that would have been a statement of fact, as that was the plan for HIA 233, and not a threat.

195 FJH 15777-15782.
196 Day 124, p.61.
197 pp.100-101, Day 124, 10 June 2015.
198 FJH 008.

204 The HSCB provided a response to HIA 233's evidence in which it set out the following recorded events:

- An untoward incident report completed by Harberton staff on Saturday 24 October 1992 recorded that HIA 233 told another girl that she had sexual intercourse with another resident, HH 18 in her room on Friday 23 October 1992.
- HIA 233, HH 18 and two other residents were spoken to about this by residential social work staff; HH 5 was informed and he in turn informed HH 40, Programme Manager.
- The Care Unit of the RUC was contacted and HIA 233's mother was approached for written consent to a medical examination, which she gave at 10pm on 24 October 1992.
- HIA 233 was interviewed at Strand Road RUC station on Sunday 25 October 1992 in connection with the allegations about HH 18; another female resident of Harberton House and HH 18 were also interviewed by the police about the matter.
- HIA 233 refused to be medically examined at the police station on 25 October 1992, and in the police statement she was recorded as being uncooperative and abusive during the interview.
- The Care Unit of the RUC informed Harberton House by letter on 9 December 1992 that there would be no further police action taken regarding HIA 233's allegations of a sexual nature against HH 18.[199]

The HSCB also confirmed that prior to this incident HIA 233 was already on a waiting list for a place in a training school, and it was because a place became available that she was transferred to Middletown Training School on 28 October 1992.

205 We carefully considered the evidence of HIA 233 and the responses from the HSCB, HH 5 and HH 22. We consider that HIA 233's allegations of rape by another resident were taken seriously and dealt with appropriately.

206 We noted HIA 233's complaints about HH 15 and that two other residents complained about his overly physical behaviour towards them and one resident complained about him being rude to her on two occasions. These complaints were investigated by managers and it was recorded that they were not upheld. We note that Mr Carey regularly reviewed the complaints made about staff and the outcome of their investigation.

199 FJH 30615.

207 Although we did not find evidence of systemic failings in the care HIA 233 received in Harberton House we consider the complaints she and other children raised about HH 15 highlight the importance of senior staff monitoring the number and type of complaints being made against a member of staff since a pattern of low-level complaints may indicate unsuitability and merit more serious disciplinary action.

Summary of Findings about Harberton House

208 **We found that the SSI on behalf of the Department failed to:**

(1) engage with the WHSSB to support it to consider how best to implement the recommendations of the Bunting Review, although it was aware adverse conditions were continuing to affect the care that children were receiving in Harberton House;

and that this failing amounted to a systemic failing to ensure Harberton House provided proper care.

209 **We found that the WHSSB failed:**

(1) in its strategic planning of Harberton House to ensure that complementary services were in place that would allow its remit as an assessment centre to be realised and protected so that it could assess the needs of children and make arrangements for them to receive planned care appropriate to their assessed needs;

(2) to instigate a fundamental review of its childcare services despite the findings of the Bunting Review and failed to increase its scrutiny of its children's homes in response to Ms McGowan's concerns;

and that these failings amount to systemic failings by the WHSSB to ensure Harberton House provided proper care.

Chapter 24:

Module 13 – Lissue Hospital, Lisburn

Introduction

1 Lissue Hospital was unique among the institutions considered by the Inquiry in that it was the only hospital to be investigated, and its functions therefore included medical and nursing care. It is not the Inquiry's role to evaluate the medical care provided, and if there remain medical issues which require investigation the task will need to be allocated to another inquiry to be undertaken by professionals with the appropriate qualifications and experience.

2 However, much of the work of Lissue concerned the residential care of children who were displaying behaviour or conduct disorders, and who might well have been cared for in other types of children's home or residential school if they had been available. Furthermore, most of the allegations made by witnesses were concerned with aspects of childcare, which is within our remit.

3 Module 13 commenced on 4 April 2016 with an introduction by Senior Counsel and we heard the evidence of ten witnesses who had been patients at Lissue Hospital as children. Sadly, one had died, and his evidence was therefore read out. Three former staff gave evidence concerning their respective roles in the multidisciplinary team - three nurses, LS 81, LS 7 and LS 21, two consultant psychiatrists (Dr William Nelson and Dr Roger McAuley), and LS 80, a social worker. On behalf of the core participants Dr Hilary Harrison spoke for the Department of Health, Social Services and Public Safety, (since renamed the Department of Health) and a joint statement was presented by Dr Carolyn Harper and Mary Hinds for the Public Health Agency and Fionnuala McAndrew for the Health and Social Care Board (HSCB). Since the closure of Lissue there have been twelve inquiries and reports based on investigations of issues related to the Hospital's functioning. Although undertaken following the end of the Inquiry's remit, their contents have a bearing on our findings, and the chapter therefore concludes with a summary of their contents. After nine days of hearings, the Module closed on 27 April.

The History and Role of Lissue Hospital

4 Lissue House was originally a private home, and in planning for the evacuation of children in the Second World War, Colonel and Mrs Lindsay offered the house to the Royal Hospital for Sick Children as a hospital for the treatment and convalescence of child patients. Thirty children were

admitted in July 1940, which was timely in view of the air raids which Belfast suffered in early 1941.[1]

5 In 1945, after the War, the hospital was closed, but the Lindsays then donated the house to the newly created Northern Ireland Hospitals Authority. After a period in which the buildings were modified it was reopened in 1949 as a paediatric hospital, addressing children's health problems current at that time, such as tuberculosis, lobar pneumonia, rheumatic fever and worm infestation.[2] By 1959 Lissue was a busy branch of the Royal Belfast Hospital for Sick Children, treating surgical and medical patients and able to house up to seventy patients.[3] It fulfilled this role for just over two decades, and two of the witnesses were patients during this time.

6 With improvements in health care, there was less demand for these types of paediatric services. A report written, in 1982, noted that the illnesses and disorders prevalent in 1948 had almost entirely disappeared.[4] There was, however, an increase in the number of children admitted with behavioural problems, and the mixture of presenting problems caused management difficulties, so that it was decided to separate the children requiring paediatric care from those with psychiatric needs.

7 By 1966 the need for a psychiatric unit was becoming urgent. A working party chaired by Professor Carré was set up in 1968 and it produced proposals for a child psychiatry unit at Lissue. It was noted that under current guidance, per million of population, 20/25 beds were recommended for the assessment and short-term treatment of children with mental health problems, 25 beds for long stay for children, and 20/25 beds for adolescents. Northern Ireland had none of these units at the time.[5] The plans were approved in 1969, largely along the lines proposed by the working party[6] and in 1970 the upper floor was closed so that the building could be adapted.[7]

8 The next stage in Lissue's history commenced in May 1971 with the opening of the child psychiatry unit. It was the first such unit in the whole of Ireland.[8]

1 LIS 079, 810.
2 LIS 792, 811, 815, 818, 824.
3 LIS 080, 126.
4 LIS 824.
5 LIS 136.
6 LIS 135-149,151.
7 LIS 080, 812.
8 LIS 715-716.

The Hospital was now split into two units of twenty beds each. There was also the capacity for five day patients in the psychiatric unit. The paediatric unit remained on the ground floor and it came to concentrate on providing care for children with physical and mental disabilities, fulfilling a useful role in supporting parents by providing respite care from 1977 onwards.[9]

9 None of the applicants to the Inquiry was a patient in the paediatric unit during the phase from 1971 to 1989. The two units were run quite separately from each other and they had very little contact, though exceptionally HIA 251 was in the downstairs unit for a while and could not understand why he was placed alongside children with multiple disabilities.[10]

10 The eight witnesses from the period of almost two decades from 1971 to 1989 were all residents in the child psychiatry unit. The descriptions below concerning this phase all relate therefore solely to the child psychiatry unit. It addressed a range of needs, including enuresis, encopresis, anorexia nervosa and sleep disorders. Out of the twenty patients resident at any one time there were usually two or three with conduct disorders or behaviour disorders, where, as LS 80 put it, the children needed to learn to manage themselves. Their ages ranged up to thirteen for most of the period, though some older adolescents were admitted.

11 Dr William Nelson, who was at that time the only consultant child psychiatrist in Northern Ireland, was the first Director of the child psychiatry unit. He was joined by Dr Barcroft, and in 1975 Dr Roger McAuley was appointed. They each brought different approaches and skills to Lissue, described more fully below. When Dr Barcroft left, he was not replaced.

12 In his statement LS 21 said that in 1975 or 1976 when he had been the ward manager for two or three years, the police questioned him about allegations of serious sexual abuse made by HIA 220. (These allegations are described more fully in the section below on allegations of sexual abuse). LS 21 denied each and every one of them.[11]

13 In 1979 the placement of nursing students from the Central School of Psychiatric and Special Care Nursing based at Purdysburn Hospital commenced, and the students spent periods of four or five weeks at Lissue.[12]

9 LIS 812, 814.
10 LIS 032.
11 LIS 60518.
12 LIS 131.

14 In October 1981 there was a 'Horizon' programme on BBC television entitled 'Breaking in Children', in which Dr Roger McAuley explained how behaviour modification worked. Two mothers and their children appeared on the programme, one of the children being a witness to the Inquiry. Dr McAuley said that behaviour therapy was successful in one case in three, which was better than other therapies, except for tranquillisers.[13]

15 In the last few years of Lissue's existence there were four complaints of abuse. First, in March 1983 LS 71 made an allegation of three instances of peer sexual abuse by an older boy in 1982 and the police were informed.[14] An inquiry was conducted by the District Administrative Nursing Officer, (Miss Acheson), as a result of which it was decided that in future no young people aged over thirteen should be admitted.[15]

16 The Department of Health and Social Services complained that it had not been informed in accordance with a Circular concerning the reporting of significant events, issued in 1973. The allegations of peer sexual abuse were clearly a matter of public concern, and the Department had learnt of them through the Irish News. This was the first example of peer abuse reported in Northern Ireland, according to Dr Hilary Harrison.[16] [17]

17 Secondly, in November 1986 LS 68 said she had been sexually abused by LS 144, a male member of staff, when she was at Lissue in 1978. The member of staff had retired and was ill. LS 68 refused to make a statement to the police, and so the Director of Public Prosecutions directed no prosecution.[18]

18 Thirdly, in November 1986 a girl reported to LS 21 her "distrust" of LS 79, who was subsequently interviewed by LS 8, the Assistant Director of Nursing. No disciplinary action was taken, but LS 79 eventually left the service.[19]

19 Fourthly, in October 1988 LS 145, an eight-year-old boy, complained that LS 146, a twelve-year-old, had indecently assaulted him at night in the bedroom they shared. After investigation by the police the Director of Public Prosecutions directed no prosecution, but LS 146, was given a warning by the police.[20]

13 LIS 116.
14 LIS 239, 241.
15 LIS 240, 31655-31690.
16 Day 200, p.3-6.
17 LIS 098-100, 1414.
18 LIS 798-799, 31612-31654.
19 LIS 102.
20 LIS 31704-31714.

20 Following an inspection by the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland in January 1987, approval was withdrawn from both the paediatric and the psychiatric units at Lissue Hospital as suitable places for nurse training, but the report in which this decision was provided appears to have been destroyed. (See below.)

21 Lissue Hospital was eventually closed in January 1989, when the staff and patients resident at that time were transferred to Forster Green Hospital in Belfast. After a period when the building was left empty and became run down, it was damaged by fire in 1996 but had been refurbished for use by the Livestock and Meat Commission and was destroyed by fire in June 2016.

22 In all, between May 1971 and February 1989, 1,124 children had been admitted to the psychiatric unit at Lissue as in-patients, with annual admissions figures to the whole hospital ranging from 201 to 501, and 250 children were treated as day-patients.[21] Dr Harrison suggested that a minimum of 4,500 children had been admitted to the paediatric unit between 1966 and 1989.[22] The total number of children who were treated at Lissue during the four decades it was open must therefore have been much greater, and could have been as many as 10,000.

23 For the purposes of this chapter, the history of Lissue Hospital can be considered in two periods of about two decades each:

(a) the first phase from its opening in 1948 to 1971 when the Hospital mainly provided paediatric convalescent care, and

(b) the second phase from 1971 to the Hospital's closure in 1989 when it was divided into two units, respectively providing paediatric and psychiatric care.

24 Following the closure of Lissue a number of complaints were made which led to inquiries by the police and the responsible authorities; these are considered in a separate section towards the end of this chapter.[23]

21 LIS 792, 793.
22 LIS 80023.
23 For a fuller history of Lissue Hospital, see LIS 809-826, which is an extract from Love, Dr. H. The Royal Belfast Hospital for Sick Children: *A History 1948 to 1998 (1998)* Blackstaff Press, Belfast. (LIS 809-826) and Lissue Hospital History 1981 (LIS 124-133). For a map of the site see LIS 12699

Legal Basis and Governance

25 After the Second World War Lissue Hospital was re-established under the Health Services Act (Northern Ireland) 1948, and was governed by the newly created Northern Ireland Hospital Authority. The Authority was accountable to the Ministry of Health and Local Government for all aspects of the hospital system. Under the Authority, there was the Belfast Hospital Management Committee, and within the Belfast area each hospital had its own Management Committee, to whom responsibility was delegated for the day-to-day running of the hospital within the policies, guidelines and systems established by the Authority. Lissue was treated as an adjunct to the Royal Belfast Hospital for Sick Children, and it was the Royal Hospital's Management Committee which was responsible for overseeing Lissue's work.[24]

26 The Health Services Act (Northern Ireland) 1971 applied to Lissue, but it was soon superseded by the Health and Personal Social Services (Northern Ireland) Order 1972. In 1973 the structure of the health and social services was changed fundamentally, and four Area Boards were created, respectively for the North, South, East and West of Northern Ireland under the Order. They were accountable to the Ministry of Health and Social Services, subsequently renamed the Department of Health and Social Services. Although Lissue provided services for the whole of the country, the Hospital was allocated to the Eastern Board (EHSSB), which took over responsibility in 1973.[25]

27 In 1973 the management of the Hospital was removed by the EHSSB from the North and West Belfast Health Trust and placed under Lisburn District.[26] [27] This followed the principle of localising management as Lissue was sited near to Lisburn. However, it was contrary to Ministry guidance. Since Lissue had a province-wide catchment, it was argued that local management was less important than the long-standing link with the Royal Hospital.[28] The Eastern Board chose to ignore the advice of the Chief Medical Officer.[29] The new arrangement caused dismay.

24 LIS 794, 796
25 LIS 793, 796.
26 LIS 815.
27 Day 200, pp.88-89.
28 LIS 815-816.
29 LIS 816.

28 The outcome was that the nursing staff became isolated from their parent hospital in Belfast, being accountable through a District Administrative Nursing Officer to a Chief Administrative Nursing Officer, both being based in Lisburn, instead of through senior hospital nursing staff to the Matron of the Royal Hospital.[30] The consultant psychiatrists were the responsibility of the Eastern Board, as was the maintenance of the building. The social workers were managed by North and West Belfast Trust and the psychologists by the Royal Group of Hospitals Trust.

29 Dr McAuley commented that:

> "The interests of different line managements resulted sometimes in a lack of empathy with the overall purposes of the Unit…there was little cohesive caring for our service, as might have occurred if we had operated under one trust".[31]

In oral evidence, Mary Hinds spoke of the multiplicity of accountability lines and communication lines, the absence of any single organisation "looking out for Lissue" and the lack of anyone in overall control.[32] The move was described as "a triumph of bureaucracy over common sense".[33]

30 Indeed, it would be difficult to design a more confusing structure of governance. It was only at the level of the Eastern Board itself that the accountability for all aspects of Lissue Hospital came together.[34] Yet the professionals involved in Lissue were expected to collaborate in this unhelpful context as a multi-professional team. It is to their credit that Lissue functioned as well as it did. **It is our view that the governance structure from 1973 onwards was a systemic failure, and it is fortunate that it did not engender serious management problems.**

Finance

31 The Hospital was funded by the Ministry of Health and Local Government (renamed the Ministry of Health and Social Services in 1965) through the Northern Ireland Hospital Authority until 1973, when responsibility moved to the EHSSB, which was resourced through the Department of Health and Social Services.

30 LIS 085, 817.
31 LIS 484.
32 Day 200, pp.91 to 92.
33 LIS 484, 817, 80018.
34 Day 203, p.28.

32 It appears that from 1973 the financial responsibility for different parts of the budget lay with different budget-holders, and no one had overall control of Lissue's finances beneath Board level. This meant that when the budget holder for Occupational Therapy Services, for example, decided to withdraw the occupational therapist from the psychiatric unit, other staff at Lissue Hospital were unable to influence the decision. Presumably there was no one at Lissue either who could reallocate monies within the budget if the professionals involved wished to change priorities.

33 Although there have been subsequent criticisms of the level of nurse staffing, shortage of resources do not, however, seem to have been a matter of general concern or complaint during the lifetime of Lissue.

Management

34 The psychiatric unit was described as "consultant-led", and Dr Nelson was named as Director of the unit. Certainly the consultant psychiatrists were the most influential professionals in the staff team and they had particular responsibilities for determining the treatment plans for their patients. However, they did not have overall control of Lissue, and the lines of accountability were much more complex.

35 Until 1973 the nurses were responsible to a senior nurse manager at the Royal Belfast Hospital for Sick Children, but after the reorganisation LS 8, the Assistant Director who managed the nursing teams in both the paediatric unit and the psychiatric unit, was answerable to senior nurses based in Lisburn. The Assistant Director appears to have had no other responsibilities, and so his narrow span of control meant that he was fully involved in the running of both units, although his office was in Lisburn. He called at Lissue every day and became involved whenever there was a major problem.[35]

36 LS 21, who was promoted in 1973 from staff nurse to ward manager responsible for the psychiatric unit, appears from witnesses' evidence to have been a much more significant figure in the life of the unit.[36] There was a considerable amount of administration to be done, such as the organisation of staff training and the oversight of sessions with families. LS 21 found this work demanding and stressful, and for a time he shared his

35 Day 198, p.75.
36 LIS 60516.

managerial role with another charge nurse.[37] LS 21 provided professional supervision for the nurses on the psychiatric ward, and they also had sessions with the consultant psychiatrists.[38]

37 Similarly the psychologists, the social workers and the occupational therapist were all accountable within their professional hierarchies to managers in other settings. The social workers were professionally supervised by an Assistant Principal Social Worker at the Royal Belfast Hospital for Sick Children, but LS 80 said this only amounted to an occasional discussion if an issue arose where advice was required.[39] LS 80, as Senior Social Worker, therefore had considerable independence, but he did not have the benefit of regular professional supervision.

38 The practice policies which have been provided were nearly all drafted shortly after Lissue Hospital was closed, but it has been suggested that they reflected standard practice at Lissue.[40]

39 In summary, while the multiprofessional staff team appears to have collaborated effectively, the structure within which they worked was most unsatisfactory. Not only was there no single senior manager outside the unit who had ownership of Lissue Hospital with the responsibility for making it function effectively, but there was no single person accountable for the running of the unit on site. The hospital was reliant on each of its constituent parts working together, both in the day-to-day running of the hospital and in devising long-term strategy, for example in developing new treatment methods or in improving staffing levels.

40 In meeting the complex needs of children with psychiatric and behavioural problems it is necessary not only to devise suitable individual treatment plans but also to create an appropriate milieu in which the treatment can be offered. The traditional respective responsibilities of nurses and doctors in hospitals do not help in this respect, as a unified approach is required. The psychiatrists were the lead professionals, but their only responsibility was for the treatment of their patients. Other staff were not accountable to them and they had no control over the hospital's budget. In short, the chaotic lines of external accountability were matched by a fragmented internal management structure. **The successes of the psychiatric unit at Lissue were thanks to cooperation between the individual**

37 LIS 60516.
38 Day 198, p.115.
39 Day 200, pp.66 to 65.
40 LIS 158-167.

professionals involved; the managerial structure within which they worked was faulty and systemically unsound.

Inspections

41 When Lissue was set up, inspection was the responsibility of the Ministry of Health and Local Government under Section 63 of the 1948 Act. Under Section 70 of the 1971 Act, and then under Article 50 of the 1972 Order the Department of Health and Social Services had the general power to inspect. However, we have received no evidence that this general power to inspect was ever used prior to 2005, when the report Care at its Best was produced.[41] [42] Dr Kevin McCoy, who was Chief Inspector of Social Services, has stated that at no stage during his employment with the Social Work Advisory Group and the Social Services Inspectorate was an inspection carried out at Lissue.[43]

42 Lissue Hospital received a number of visits, three of which could be considered inspections. One was by the District Administrative Nursing Officer to investigate a specific complaint, one by the Mental Health Act Commission to review mental health services, and one by the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland to assess the Hospital for training purposes. There are no records of regular formal visits of inspection by the Departments, boards and committees responsible for the Hospital's services.

43 In the Belfast Hospital Management Committee Annual Report for 1971 Dr McSorley was named as the visitor for Lissue, but because of civil unrest, visiting was abandoned. There are no reports of such visits, and former staff felt that their purpose was predominantly familiarisation.[44]

44 The Royal College of Psychiatrists would ordinarily have arranged visits of inspection to units such as Lissue Hospital "every three years to examine the educational content of training and professional development of doctors", with inspections taking around two days, but no evidence has been found.[45]

41 Day 200, p.23.
42 LIS 087, 795, 827-961.
43 LIS 1450.
44 LIS 090, 188.
45 LIS 091.

45 The education provided at Lissue was subject to inspection by the Northern Ireland Department for Education Inspectorate, but we have no reports of inspections.[46]

46 On the afternoon of 20 May 1976 five members of the Eastern Health and Social Services Board accompanied by four professionals visited two hospitals, one being Lissue. They commented on the gross underuse of the paediatric unit, the overcrowding in the psychiatric unit and some dry rot. Although the notes of the visit commented on the high quality of paediatric nursing and the variety of psychiatric techniques available, the visit appears to have been made primarily to acquaint the Board members with the nature of the hospital, rather than as an inspection to ascertain the quality of services provided.[47]

47 LS 71 complained in 1983 of buggery by a fellow patient two years earlier, once he had moved on to Marmion children's home. The police were called in to investigate. The alleged abuser, LS 72, admitted buggery, and the police wanted to prosecute him but the Director of Public Prosecutions felt it was inappropriate.[48] [49]

48 The complaint was taken seriously, and the District Administrative Nursing Officer from Lisburn (Miss Acheson) made a visit of inspection. LS 8 was called in from annual leave to assist with the investigation.[50] [51] Miss Acheson's report was thorough and considered all aspects of the nursing task, staffing numbers and management, and other matters. She acknowledged that, assuming the allegations were true, Lissue's policies and systems had not protected LS 71.

49 She concluded that the unit was being well run, with one reservation, that the large number of children aged fourteen and over provided an element of risk and caused stress.[52] Nursing staff raised concerns about the treatment of older teenagers as day patients at Lissue because of the "strains" which this imposed.[53] According to Dr Nelson the school teachers were also concerned when older, stronger children were admitted.[54] In

46 LIS 803.
47 LIS 13644.
48 LIS 239, 31655-31690.
49 Day 201, p.62.
50 LIS 1414-1422.
51 Day 200, p.92.
52 LIS 236-237, 1415-1422.
53 LIS 1415.
54 Day 201, p.139.

consequence he decided that in future no young people aged over thirteen should be admitted.[55]

50 Dr Nelson recalled that Martin Bradley, who was later appointed as Chief Nursing Officer, made an inspection of Lissue.[56] We do not have a date or a report for this visit, and Martin Bradley has since said he was not involved in inspecting, or even visiting, Lissue.[57]

51 The remaining visits and inspections all took place in the last two years of Lissue's existence. The Mental Health Commission was established under Article 85 of the Mental Health (Northern Ireland) Order 1986, and under Article 85 it had a limited role to "keep under review the care and treatment of patients" and draw deficiencies to the attention of the appropriate authorities.[58] There is a record of a visit by two members of the Mental Health Commission for Northern Ireland on 5 January 1987 which suggests that other annual visits were planned.[59] No further reports have been found, but Lissue was closed less than two years later.[60]

52 The visit record was on a standard form which contained a description of the psychiatric unit, and the Commission also called in on the paediatric ward, which at that time was largely used for children with learning disabilities. With regard to the psychiatric unit, it was reported that patients did not have written treatment plans but that the notes of the ward rounds were used as the basis for treatment by nurses. Patients were followed up for a month after discharge, and were sometimes referred to outpatients for child guidance. The Commission were told that seclusion of patients was never used. The Commission's conclusion was that there was good multidisciplinary teamwork, though there was some concern about the adequacy of the staffing and the nurses complained that apprehending absconders should have been the responsibility of the social workers.[61]

53 The most significant visit was made by the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland, which conducted an inspection in January/February 1987 to consider the suitability of Lissue Hospital for nurse training. It should therefore have been a qualitative

55 LIS 240.
56 Day 201, p.149.
57 LIS 80005.
58 LIS 088, 794, 795.
59 LIS 13522-13533.
60 LIS 088.
61 LIS 088, 173-175, 796, 13522-13533.

inspection. No copy of the report has been found, but as a result of the visit approval of Lissue to be used for nurse training was withdrawn. At any one time there had been two student nurses working in the psychiatric unit and this arrangement ceased.[62]

54 On 8 April 1987 the Education Committee of the National Board considered that their grave concerns should be drawn to the attention of the EHSSB and on 9 December 1987 their minutes record a response from the Chief Administrator of the EHSSB to note that many of the items had been dealt with promptly.[63]

55 According to a brief summary in a memorandum dated 10 June 1988, the layout of the unit was "not seen as well suited for its present use" and "the philosophy of care was seen as restrictive and 'custodial'", because of the locking of doors, though the Mental Health Commission, which visited in the same month, did not comment on this. Eight requirements were listed for re-appraisal, ranging from the need for a philosophy of nursing care to the storage of videotapes, but there is no evidence that any application for re-approval was ever made.[64] [65]

56 Neither Dr Nelson nor Dr McAuley were informed of the withdrawal of recognition[66] and Dr McAuley said that, as the Assistant Director of Nursing Services, LS 8 had been remiss in failing to share information. He felt that this matter should have been discussed with the consultant psychiatrists and suspected that the decision might not have related to the quality of nursing so much as to a rationalisation of the training provision.[67]

57 While formal inspections had their limitations, they could have provided an opportunity for experienced professionals to check the quality of provision, to determine whether prescribed standards were being met and to observe the quality of medical and nursing services. When a unit was geographically isolated, as Lissue was, with relatively few outsiders visiting, it was particularly important that such inspections should take place, both on a formal regular basis and informally unannounced.

58 Because of their age and the types of presenting problems from which they suffered, the children were clearly vulnerable and in no position to speak for

62 LIS 13813, 80053-80055.
63 LIS 1087-1088, 1103.
64 LIS 091, 226, 1090-1091.
65 Day 200, pp83 to 84; Day 201, p.141.
66 Day 201, p.83.
67 Day 201, p.80.

themselves. Similarly, their parents, who visited on occasion, were often badly placed to make complaints, in view of their dependence on Lissue to cope with their troubled children. Nor have we found any references to other visitors who might have acted as advocates to ensure that the children were being well treated, such as clergy, general practitioners or independent representatives. External inspections were therefore of considerable importance.

59 We infer from the absence of references to formal inspections that, if they took place at all, they must have been at best very infrequent, and since one of the two external inspections of which we are aware resulted in the withdrawal of recognition of Lissue as a nurse training hospital, the lack of external scrutiny is clearly a matter of concern. The absence of any further information means that any detailed conclusion has to be conjectural, but it is plainly possible that some of the practices which were later subject to criticism could have been identified and dealt with at an earlier stage if there had been a system of inspection.

60 The Department of Health submitted that "it was not a failing of the Department not to have inspected Lissue Hospital".[68] Within the legal framework at the time this was true, as there was no prescribed duty for the Department to inspect hospitals. However, while the legislature bore the responsibility for debating and approving the legal framework, the Department and its predecessors were also responsible for the drafting of legislation, not just its implementation in practice. Neither the legislation nor the Department's policies provided for any system of inspection for Lissue Hospital, and, with the exception of the nursing inspection following the complaint made by LS 71, the visits which were made by those responsible for the overall management of the service or by senior professionals were essentially for their own information or for specific professional purposes, rather than the inspection of the services.

61 The Department of Health defended their predecessors' failure to inspect by pointing out that there were "layers of oversight" by professionals who had their own codes of conduct, that there were multidisciplinary meetings and children's meetings, and that the children were in frequent contact with their parents.[69] These measures were all useful, but they were no substitute for the regular, external, independent, expert surveillance which an inspection system should have provided.

68 LIS 80012.
69 LIS 80006, 80012.

62 Dr Harrison said that inspection was "a blunt instrument" which was unlikely to have identified abusive practices.[70] [71] Certainly, formal announced inspections have their limitations as it is possible to put on a show for the inspectors, but they are invaluable in establishing the standards expected of a service, in checking records and physical conditions, and in prompting possible complainants. They can also be backed up by unannounced visits. The "bluntness" of formal inspection is not a sound argument for its abandonment.

63 **In the circumstances we consider the absence of both formal inspections and informal monitoring of Lissue Hospital on a regular basis to have been a systemic failure on the part of the Ministry of Health and Local Government and the Northern Ireland Hospital Authority from 1948 to 1973, and on the part of the Ministry/ Department of Health and Social Services and the Eastern Health and Social Services Board from 1973 to 1989.**

Staffing

Multidisciplinary Teamwork

64 The staffing of Lissue Hospital was multidisciplinary.[72] In the Stinson Report (discussed below) there was criticism of the multidisciplinary working within the psychiatric unit, but witnesses reacted strongly against this observation. LS 81, for example, said that communication between the disciplines was good, and she found the consultant psychiatrists "always receptive and helpful" in responding to queries and talking through matters raised.[73] Although there are some references in the documentation to tensions between professional groups, they are relatively minor, and the general impression which we have received is that working relationships in the hospital were sound.

65 In December 1993 it was reported that in addition to the medical staff, psychologists, social workers and teachers, there was a total complement of 73 staff at Lissue, including 39 nurses and 30 ancillary staff, who covered both the psychiatric and paediatric units.[74]

70 LIS 80007-80008.
71 Day 200, p.27.
72 LIS 1197.
73 LIS 1200.
74 LIS 093.

Nurses

66 The psychiatric unit was staffed by a team of nurses who, in later years, had to have achieved the status of Registered Mental Nurse. Dr McAuley said that staffing provision was roughly in line with the levels recommended by the Royal College of Psychiatrists in 1971.[75] LS 81 said that short staffing was not "a prevailing memory" during her time at Lissue between 1984 and 1986.[76] LS 21 reported occasional staffing shortages because of illness, holidays and so on, but did not think it was a general problem.[77]

67 The Stinson Report identified four children out of a sample of 34 who required intensive care at a level beyond the available staffing. Restraint placed particular demands on staff time.[78] Concern was expressed by Mary Hinds that the level of staffing at Lissue had been insufficient, in that it amounted to 1.3 nurses per bed, when the current recommended ratio is now 3.3 nurses per bed. She thought that when occupancy rose the staff might have experienced stress.[79]

68 LS 7 said that, contrary to some of the other evidence,[80] staff turnover was low and in oral evidence she named four or five nurses who remained in the psychiatric unit for long periods of time. Indeed, some of them moved on to Forster Green Hospital after Lissue's closure, and spent their whole nursing career in work with children. Miss Acheson also mentioned low staff turnover when she reported on Lissue in 1983.[81] A core of staff who provided long-term service would have been helpful in the establishment of consistent standards. While Lissue was involved in providing training placements there would, of course, have been a steady turnover of student nurses.

69 Information was provided by the HSCB drawn from personnel records concerning nine staff.[82] Many of them had long careers in child psychiatric nursing; LS 7, for example, worked in Lissue and Forster Green for nineteen years,[83] and LS 8 was promoted five times in the course of his nursing career of 35 years, having been charge nurse, nursing officer and Assistant Director of Nursing Services at Lissue.[84]

75 LIS 481.
76 LIS 1199.
77 Day 199, p.54-55.
78 LIS 12290.
79 Day 200, p.78.
80 LIS 13533.
81 LIS 1420.
82 LIS 60522-60525.
83 LIS 60522.
84 LIS 60523.

70 Only one of the staff was subject to disciplinary action. LS 21 commenced as a staff nurse at Lissue Hospital in 1971 and was promoted to charge nurse (or Ward Manager) in 1973, a position he held until 1989, when he transferred to a similar position at Forster Green as Lissue was closed. Although there were police investigations in 1975 or 1976, LS 21 was not suspended. He was placed on precautionary suspension, however during police investigations in May 1993 into allegations made by LS 66 the police were unable to obtain any evidence to support the allegations from other possible witnesses, and he was re-instated in October 1993 when the police decided to take no action.[85]

71 When police undertake inquiries of this kind they are seeking evidence which will be sufficient to prove the guilt of the alleged abuser beyond reasonable doubt. If an employer is considering the dismissal of a member of staff on the grounds of the abuse of a patient, they require the lesser burden of proof on balance of probabilities. However, the employer has a primary duty to protect the patient and should consider action if there are reasonable suspicions of improper practice.

72 In this instance the EHSSB relied on the decision taken by the police and appears to have undertaken no independent enquiries to satisfy itself whether a lower burden of proof was met. By re-instating LS 21 without undertaking such investigations the Board left patients vulnerable and it is possible that any who made allegations at a later date might not have been subjected to abuse if action had been taken. (Green Park Trust was a Unit of Management within the EHSSB and was designated by the EHSSB at the relevant time as the employer of LS 21).

73 **While we cannot say what the outcome of a disciplinary inquiry might have been, we consider the failure of the Green Park Trust to conduct its own investigations into the allegations of sexual abuse against LS 21 in 1993 to have been a systemic failure which left children at risk of abuse.**

74 LS 21 was again suspended in April 1996 for working for an agency while off work because of ill-health and for leaving a child who presented a risk of suicide unattended. He took early retirement in July 1996 on the grounds of ill-health; it was suggested that the police investigation in 1993 had

85 LIS 60524.

affected his health.[86] In oral evidence, LS 21 said that work at Lissue was "challenging, stressful but joyous at times".[87] He had been proud of his achievements, but what was now alleged was not what he recalled, and he felt he had chosen the wrong profession.[88] During his time at Lissue things changed "in a more progressively improving way".[89]

75 LS 7 was trained as a nurse in the 1940s, and although she had no specific mental health training, she joined Lissue Hospital in June 1975. She worked there until Lissue was closed and she moved with the service to Forster Green Hospital, retiring in 1994. She worked throughout as a staff nurse, acting up occasionally in the absence of senior colleagues.[90] LS 7 spoke appreciatively of her work. LS 7 said that nothing changed during her fourteen years working in the unit.[91]

76 Although never subject to disciplinary action, LS 7 was the nurse who was subject to most allegations of physical abuse. HIA 38, HIA 119 and HIA 172 all made allegations against her on the grounds of rough treatment. She said she was subject to only one complaint during her career, and that she had been exonerated.[92]

Psychiatrists

77 While the nursing team was dedicated to Lissue Hospital, the consultant psychiatrists, the psychologists and the social workers were shared with the Royal Belfast Hospital for Sick Children.[93] For much of the time from 1971 to 1989 there were two consultant psychiatrists,[94] and Dr Nelson and Dr McAuley both gave written and oral evidence to the Inquiry. Each of them was responsible for a number of the patients.

78 Dr Nelson's philosophy was eclectic.[95] He introduced family therapy, and with the increasing appreciation of importance of family dynamics, parent accommodation was added in 1977 so that family interactions could be observed and parents could be helped with parenting skills.[96] In

86 LIS 60525.
87 Day 199, p.74.
88 Day 199, p.80.
89 Day 199, p.53.
90 LIS 1390.
91 Day 201, p.64.
92 LIS 1389.
93 Day 198, pp.74 and 81.
94 LIS 715.
95 LIS 715.
96 LIS 082, 812.

1978 Dr Nelson introduced a family therapy model, based on Dr Salvador Minuchin's work in Philadelphia, which entailed involving as many family members as possible in sessions at Lissue.[97]

79 In 1975 Dr Roger McAuley joined Lissue Hospital and introduced a behaviour modification programme in 1976, which was then a new approach in working with children. This became:

> "…the principal direction of care, with staff from all the disciplines adopting a behavioural philosophy in their work".[98] In 1977 he wrote a text on the subject, *Child Behaviour Problems: An Empirical Approach to Management*.

80 Dr John Barcroft worked at Lissue between 1976 and 1978. His approach was psychotherapeutic. When he left he was not replaced, and his workload was absorbed by Dr Nelson and Dr McAuley.[99]

81 There was also a senior registrar present throughout the working week. Registrars were medically qualified and undertook six-month placements as part of their training as psychiatrists. They did not carry caseloads but were able to advise staff, prescribe drugs and treat children medically.[100]

82 A number of different theoretical models were therefore in use at Lissue Hospital at any one time. LS 81, who had worked as a nurse at Lissue, noted:

> "These [different theoretical models] required different approaches with different children, and they were both of their time. Many of the techniques were new and innovative at that time in relation to the video undertaking with the families".[101]

In oral evidence she added that in the running of the unit the behaviourist model was adopted by the nurses and tended to be dominant in the way children's behaviour was managed. LS 80 thought behaviour modification was particularly applicable, and when it became the dominant mode for the running of the unit, he found the ethos helped children with other types of problem.[102]

97 LIS 716-717.
98 LIS 812, 480, 716, 812.
99 Day 201, p.68.
100 LIS 481.
101 LIS 1197.
102 Day 200, p.49.

83 HIA 38 complained that he felt that he and other children were the subjects of experimentation.[103] As the lead professionals, the psychiatrists were no doubt seeking new ways of meeting children's needs and were themselves learning in the process. However, we came across no evidence that formal research experiments were being conducted, nor that children were being in any way exploited in the search for new approaches. With the exception of certain incidents considered in the section on the witnesses' allegations, the treatment offered appeared to have been primarily with the children's best interests in mind.

Dr Morris Fraser

84 It is probable that Dr Morris Fraser worked at Lissue Hospital as a Senior Psychiatric Registrar in the course of his training as a psychiatrist, as he was employed as a senior registrar at the Royal Belfast Hospital for Sick Children in 1970. In August 1971 he took a thirteen-year-old boy to London, and the boy later complained that Dr Fraser had indecently assaulted him.[104] On 17 May 1972 Dr Fraser pleaded guilty to a charge of indecent assault at Bow Street Magistrates Court. It is reported that the Northern Ireland Hospitals Authority was unaware of these events at the time, and Dr Fraser continued to work in Belfast.[105]

85 As one of eight people involved in "the abuse of boys on an international scale" Dr Fraser was convicted again of sexual offences against a child in New York in May 1973. This was reported in the press, and when he applied for a post as consultant psychiatrist in Belfast in 1973 the authority learnt of the conviction on the day of the interview, his interview was cancelled, and he ceased to work with children in Northern Ireland.[106]

86 Dr Fraser was found guilty of serious misconduct by the General Medical Council, (GMC) which deliberated on four occasions between July 1973 and July 1975 about the most appropriate sanction to apply. Strangely, however, the GMC does not seem to have taken account of his offending in New York and having postponed making a decision for two years and sought reassurances from Dr Fraser's colleagues, the GMC did not strike Dr Fraser off but decided to discharge his case and let him continue to practise.[107]

103 LIS 053.
104 LIS 120.
105 LIS 121.
106 LIS 121.
107 LIS 474-479.

87 There is no evidence of Dr Fraser's work at Lissue, or that he abused any child at Lissue, and no one has made a complaint. Dr Fraser continued to work elsewhere as a psychiatrist, though not with children, and he then took early retirement.[108]

Other Staff

88 There was also a clinical psychologist, two social workers and an occupational therapist, though the latter post was removed in 1978 despite the objections of the consultant psychiatrists.[109]

89 LS 80, was a senior social worker who worked throughout Lissue's period as a psychiatric unit. There were usually two social workers, working from Monday to Friday, and their workload consisted of both resident and day patients. Their work focused on supporting the children's parents and understanding the overall functioning of their families. They liaised with the community-based social workers who worked with the children, and they provided advice and support to the staff of children's homes when patients were discharged into residential placements, informing them about what had been learnt at Lissue. The social workers also participated in the family therapy sessions, but not in the children's morning meetings.[110]

90 There were also ancillary staff, and the children were not required to undertake any domestic tasks, other than tidying their bedrooms.[111]

91 Staff in the psychiatric unit not only wore casual clothes to create a less formal atmosphere in the unit, but both the medical and nursing staff also called each other by first names, rather than rank and surname.[112] This meant that children often did not know the surnames of staff, which has made the identification of alleged abusers more difficult in some cases.[113] Nurses continued to wear uniforms in the paediatric unit.[114]

Staff Training

92 Although in the early years, nurses who had had general nurse training were acceptable, such as LS 7, it became a requirement for applicants

108 Day 201, pp.103 and 104.
109 LIS 481, 715.
110 Day 200, pp.42 to 43.
111 LIS 1206.
112 LIS 007, 60516.
113 Day 198, p.81.
114 LIS 1390.

to hold the RMN (Registered Mental Nurse) qualification and the syllabus included a unit on child and adolescent psychiatry. A specialist training course in child and adolescent mental health was developed at the Purdysburn School of Nursing in 1990. It later transferred to Queen's University and was registered by the Nursing and Midwifery Council as a recognised course.[115] This lasted for fourteen months on day release.[116]

93 There was a monthly "journal club" where doctors, nurses and social workers came together to consider training and practice issues through presentations on research, cases or other subjects.[117]

94 There were also occasional classes for the nurses on specific subjects, including behaviour therapy, family therapy, child sexual abuse and medical conditions such as enuresis.[118] Nurses gave evidence that they had been trained in restraint, but others said that they had learnt by observing colleagues.[119]

95 Student nurses spent four to six weeks at Lissue as part of their RMN training, until 1987 when the hospital was no longer recognised as fit for the purpose.[120]

The Premises

96 Lissue House was situated just off the Ballinderry Road in the countryside on the west side of Lisburn. The rural setting would have been seen as helpful for children convalescing, and the siting near Lisburn meant that contact could be readily maintained with the Royal Belfast Hospital for Sick Children, which was the source of most referrals.

97 Approached by a long drive, Lissue House was a large building, with a spacious entrance hall and a grand staircase, surrounded by extensive grounds providing space for play. On the ground floor there were offices and the paediatric unit. The site was sloping, which meant that while children in the paediatric unit had direct access to the grounds, so too did the residents in the psychiatric unit on the first floor. One witness described the paediatric unit as being at the front of the building, while the psychiatric unit was at the back.[121]

115 LIS 1197.
116 Day 198, pp.123 to 124.
117 LIS 1198.
118 Day 198, p.78.
119 LIS 80043; Day 198, p.84; Day 199, p.48; Day 200 pp.63 to 64; Day 201, p.97.
120 Day 199, p.40.
121 LIS 007, 12837-40.

98 Within the building there was a staircase leading up to the psychiatric unit on the first floor and according to HIA 220 the door at the top of the stairs which led into the unit was kept locked.[122] The building was not ideally suited to childcare, and there were complaints that it was difficult to supervise the children because of the length of the corridors.[123]

99 The psychiatric unit was on two floors. Along one corridor on the first floor there were the kitchen and TV room and in the opposite corridor there was the dining room.[124] There were three four-bedded dormitories and one with eight beds, totalling twenty bed spaces.[125] Other than for babies, the dormitories were single sex.[126] A hobbies room, which had originally been the occupational therapist's room, was set aside for a train set, complete with papier maché countryside. The children played with the train as a special treat and HIA 38 described it as the Holy Grail of Lissue.[127] There was also a billiards room and a playroom with a rural mural painted by LS 21.

100 Beyond the dining room there were stairs to the eight single bedrooms, which were usually allocated to older children.[128] One single bedroom was fitted with a window for observation; HIA 251 recalled being in this room.[129] HIA 172 and HIA 38 both said that they had their own bedrooms.[130] HIA 38 said that there were bars on his window which prevented it from opening more than a few inches. He also said that the bedroom doors were locked at night, though staff have denied this.[131] There was also a sitting room on the upper floor, and a small kitchenette for dispensing drugs.[132] [133]

101 The buildings had been adapted to provide for the needs of psychiatric care. The bothy from the original building was incorporated into the provision and was used to house children's families, so that work could be undertaken on parenting and family therapy. Two rooms were set aside for observation, so that professionals in one room could observe children

122 Day 197, p.7.
123 Day 201, p.67.
124 LIS 008, 022.
125 LIS60516.
126 Day 198, p.27.
127 Day 198, p.27.
128 LIS 1204.
129 Day 198, p.90.
130 LIS 008, 049.
131 LIS 050.
132 Day 198, p.114.
133 LIS 1416.

and their families in another room where video recordings could be made for later analysis. HIA 38 recounted that he ran into the observation room one day and saw the shelves full of video recordings and the cameras for the staff to observe.[134]

102 Some of the rooms were gathered round a courtyard where the adjoining buildings were only one storey high, fronted by a verandah supported by pillars, and incorporating a bungalow. During disturbances children could gain access to the roof at this point and several did so. When HIA 172 jumped off the roof he hurt his ankle, and the concern caused was such that LS 8, Assistant Director of Nursing, issued an instruction that HIA 172 should be under constant supervision, irrespective of the views of medical staff, as he constituted a suicide risk.[135] Dr McAuley also issued guidance about the way incidents should be managed when children were on the roof.[136]

103 Although recommended by Dr McAuley, no one seems to have taken any action to prevent children from being able to climb onto the roof. The Eastern Board were responsible for the premises, and the failure to take preventative action may have been a symptom of the confused management structure. The HSCB has pointed out that this problem dated back to the time before risk assessments were undertaken with the implementation of the Health and Safety at Work (Northern Ireland) Order 1978, but addressing dangers of this sort should have been a matter of common sense long before the Order placed statutory requirements on employers. **In view of the risk to the children who climbed on the roof and the danger which they caused to other people, the lack of action to prevent access to the roof was a systemic failure.**

104 Immediately outside the main buildings there was a play area and the three (or possibly five) classrooms were beyond that, sited in two portacabins. The estate was surrounded by fields, one being a paddock where there was a chestnut brown pony called 'Pepper', which HIA 220 recalled riding.[137] LS 21 said that the hospital did not have any pets, and the pony may have been in a neighbour's field.[138] At the rear of the estate there ran a railway line. In the grounds there was also a large sandpit where the children used to tunnel, as if trying to escape.[139]

134 LIS 050.
135 LIS 1214.
136 LIS 166.
137 LIS 023.
138 LIS 60518.
139 Day 198, p.28.

The Patients

105 Throughout its existence, most of the children admitted to Lissue Hospital were referred through the Royal Belfast Hospital for Sick Children, though general practitioners at times referred children directly to Lissue. In the earlier years, grounds for admission included convalescence after operations or the relief of other hospitals when the number of children with tuberculosis peaked.

106 Once the psychiatric unit was open, the referrals reflected a wide range of problems, including conduct and behaviour disorders, phobias, school refusal, anxiety, depression, self-harming, anorexia nervosa, psychoses, obsessional compulsive disorders, encopresis and enuresis.[140] Children still came via the Royal Hospital out-patients, but social workers also referred children presenting behaviour problems directly to Lissue.[141]

107 Dr McAuley noted that the closure of some children's homes resulted in a higher concentration of children with acute problems in the remaining homes, with consequential increases in difficult behaviour.[142] This resulted in pressure to admit children with behavioural, rather than psychiatric, problems in growing numbers, and for Lissue to take in older children, which was resisted.

108 Dr Jacobs, who was invited in 2010 to assess the quality of treatment provided by the Hospital, criticised Lissue for attempting to meet the needs of children who required a long-term secure and safe environment, (See paras. 275 to 276) for a précis of his report). Dr McAuley, though, responded by pointing out that such placements did not exist in Northern Ireland. He argued that:

> "… government policy makers, by omission, need to share some of the responsibility for institutional abuse!"[143]

Lissue was not a long-term unit, and if lengthier treatment was required a child might be recommended for a therapeutic unit in England, though this was infrequent because of the cost.[144]

140 LIS 482.
141 LIS 117.
142 LIS 486.
143 LIS 486.
144 Day 200, pp.57 to 58.

The Witnesses

109 Of the thousands of children who were admitted to Lissue between its opening in 1949 and its closure in 1989, only ten have come forward as witnesses to the Inquiry. Many more were recorded as having been abused, however, in the course of previous investigations. Moreover, the victims of abuse in the previous investigations were drawn from fairly small samples of patients, such that the total number of possible abused children could be higher.

110 In view of the small number of witnesses, it is difficult to draw general conclusions about them as a group, but a number of features emerge.

111 Only two of the ten were at Lissue in the first nineteen years of the hospital's existence, and the other eight all attended the hospital's psychiatric unit during its last eighteen years. The bulk of this chapter therefore relates to life in the psychiatric unit.

112 Eight of the witnesses were admitted to Lissue between the ages of seven and thirteen (ie broadly during the latency period), with two being much younger. Although some older adolescents were treated at Lissue, there were no older teenagers among the witnesses. This would have contrasted with children's homes and training schools in the 1970s and 1980s, where the population was increasingly made up of older adolescents.

113 Some of the witnesses said they had been transferred to Lissue very suddenly, without being told where they were going or why.[145] When giving evidence, some said they were still unaware of the reason for their admission, though health service records were able to indicate why they were admitted in some cases.

114 The witnesses' histories differed greatly from each other. Most stayed at Lissue for a few months while their problems were assessed and treatment plans were formulated. A small number had serious physical illnesses, and they required longer term treatment and convalescence, in one case over three years. Some had specific behavioural problems which required medical or psychiatric treatment, such as hyperactivity, encopresis and enuresis. In a few cases the children were displaying unusually disturbed behaviour immediately prior to admission, such as trashing a bedroom in a children's home, and in these cases they generally returned to the children's home or moved on to a training school after a period of assessment. As Dr

145 e.g. LIS 022, 030, 069, Day 196, pp.22 and 29, Day 197, p.5.

Nelson observed, such cases were not necessarily psychiatric in nature, but there was no other facility which could manage them. Lissue had to cope with them in the absence of the specialist residential facilities which would have been found in large cities in other parts of the UK.[146] The mixture of age groups and presenting problems would have added greatly to the complexity of the residential childcare task.

115 LS 81 wrote of:

> "…the combination of children demonstrating and presenting behaviours that were described as difficult, high risk and unacceptable. It was a challenging environment to work with, children who were clashing with one another from a cultural and behavioural perspective. The ward promoted a neutral cultural environment but on occasions the history of Northern Ireland, the children and their cultural, social and family backgrounds had to be given very careful consideration."[147]

116 As Lissue Hospital was the only unit of its kind, the children were drawn from all over Northern Ireland, and they came from all sections of the community, as the admissions register indicates, in particular with a mixture of children from the Roman Catholic and Protestant communities.[148] It has to be recalled that the psychiatric unit was opened at the height of the Troubles, and while Lissue Hospital does not appear to have been involved directly, many of the children would have experienced violence or fear of serious danger in their home communities. HIA 220, for example, attributed his Attention Hyperactivity Disorder to having witnessed a shooting near his grandmother's home in Belfast and then having seen a soldier being violent to a nun as she administered last rites to the injured man.[149]

Daily Life

117 Medication was issued before breakfast. HIA 220 recalls being prescribed Ritalin. After breakfast and before school there was a meeting for all the children in the unit (except the youngest), at which they all sat in a big circle with cushioned seats, and the children could raise unresolved conflicts and announcements could be made. LS 21 said that he had introduced

146 LIS 716.
147 LIS 1201.
148 Day 198, p.108.
149 LIS 021.

the meeting, which lasted from fifteen to twenty minutes, and that it proved most helpful in resolving difficulties between children, and helped to settle them down for the day ahead. This meeting appears to have been a measure to help the unit run smoothly, rather than have any therapeutic purpose, and it was not attended by the consultant psychiatrists. There was a black mirror along the back wall, and behind the mirror was the observation room with three video cameras pointing into the room.[150] [151]

118 HIA 421 said that as she did not find the staff approachable she never felt safe to raise issues.[152] HIA 220 said:

> "Yes, you could say things, but on the abuse side of it you couldn't because there was a fear factor there."[153]

119 There was a handover meeting at 9.30am at which any issues raised in the children's meeting were discussed by the staff; the consultant psychiatrists participated in the handovers.[154]

120 Schooling started at 9am and continued until lunchtime at 1pm, with a mid-morning break. Schooling continued from 2pm to 3pm and the evening meal was at 5pm. Education was provided to the bedside in Lissue's earlier years, but in 1956 prefabricated classrooms were provided by the South Eastern Education and Library Board. There were four teachers.[155] Where children presented serious behavioural problems in class they were removed by nurses and placed in their own rooms, where on occasion they were provided with work to do on their own.

121 HIA 38 commented that he did not:

> "get much of an education at Lissue. Basic numeracy and literacy were taught but I did not learn much."[156]

In view of the wide range of ages and abilities among the patients at Lissue and the fact that most only stayed for a few months, it will have been difficult for the teachers to develop an effective educational programme. The records show a varied curriculum and good daily recording of the children's activities and progress reports.[157]

150 LIS 050.
151 Day 198, p.12.
152 Day 196, p.34.
153 Day 197, p.10.
154 Day 201, p.71.
155 LIS 820, 13531.
156 LIS 053.
157 LIS 657 to 668, 760 to 767.

122 The children were divided into three groups, which related to their age. The blue group was for young children up to the age of five, the green group was for children aged six to eight, and the red group was for children aged nine and above.[158] HIA 119 said that there were only two groups, and this could perhaps have been at a time of low occupancy.[159] The children stayed in these groups for meal times and recreation, with each group having three staff attached.[160]

123 After tea, the children then played - often outside - until supper at 9pm, though bedtimes varied according to the age group.[161] HIA 38 said that 'association time' was from 6pm to 7.30pm and that during this time, the children could watch television, play games, play football or table tennis, take up arts and crafts activities, or use the tuckshop.[162]

124 A communal set of toys was kept in a cupboard and the children were allowed to play with them at 'group time'.[163] HIA 172 said that toys were rationed; children were not allowed to have their own toys as that would have been unfair on children who had none, and his mother had to take away some which she had brought for him.[164] Unlike other residential childcare provision we have investigated, at Lissue there was no expectation that children would undertake chores, though they were expected to keep their own areas in their bedrooms tidy.[165]

125 Most children went home at weekends, leaving only three or four in the unit, and the daily programme was modified. There were weekly swimming trips, outings to the North Antrim coast, church attendance on Sundays and days out to watch the Orange marches. LS 7 felt that the children were "all spoilt".[166]

126 Children whose parents gave permission were allowed to smoke. This was a practice of which LS 7 disapproved, and she refused to hand out cigarettes to the children. In oral evidence she described how she searched one boy thoroughly for cigarettes, which she eventually found hidden in his underpants and shoes; she considered him "a vicious deceitful bully".[167]

158 Day 198, p.50.
159 LIS 002.
160 LIS 002.
161 LIS 023.
162 LIS 050, 482.
163 LIS 008.
164 Day 197, p.131.
165 LIS 113.
166 Day 201, pp.7,10 and 11.
167 Day 201, pp.13 to 14.

127 Dr Nelson said that he called in at Lissue:

> "...every day at different times of the day and also during night hours, with unannounced visits, talking to staff/children and walking round the unit".[168]

In view of his frequent visits Dr Nelson wrote that he was "very saddened" that staff had not felt able to approach him about the issues highlighted in the later reports.[169]

128 However, the nurses were the most constant figures in the children's lives, as they looked after the children whenever they were not in school. In practice this meant up to 9am in the mornings, in break times, from 3pm in the afternoon on school days, and all day at the weekends and during school holidays. The nurses used the school time for record keeping and meetings to discuss the patients.[170]

Family Contact

129 Children treated at Lissue Hospital were usually in close contact with their families. Most went home every weekend, but parents also visited the children during the week. For those undergoing family therapy there were sessions which were observed from the next room and recorded on video for later analysis; these involved as many members of the close family as possible.

130 The frequent contact with parents was considered by the Department to safeguard the children against abuse, as they had regular opportunities to complain or to let slip indications that they were being abused. The children's families also had access to the Hospital's complaints procedure.[171]

131 LS 21 said that as ward manager he made home visits occasionally, but that family contact was usually left to the social worker.[172]

Case Management

132 Nursing staff worked in teams of three in relation to individual children, one acting as the key nurse, the second nurse being in support, with

168 LIS 716.
169 LIS 718.
170 LIS 60515, 60518.
171 Day 200, p.28.
172 Day 199, p.75.

a health care support person being the third. This system should have meant that, allowing for time off and other absences, there would have been a member of the threesome present every day.[173]

133 At the conclusion of every shift, nurses were expected to write a report on the progress of each patient in relation to the implementation of the child's treatment plan. For a child with encopresis, for example, this would have included the recording of information on nutrition, fluid intake, toileting and psychological factors. Sleep patterns were also monitored at regular intervals in the night. The records in the documentation were factual and descriptive, and appear to have made no attempt at identifying the causes of the children's behaviour patterns. At the end of both the day and the night shifts there was a handover briefing, with a senior nurse staying on duty to oversee the children while the other staff held detailed discussions.[174]

134 A variety of records were maintained - admissions books, case records, medical and nursing notes, for example. Other professionals, such as social workers and psychologists, maintained their own records.[175] When patients were discharged, their notes were combined in one main file and forwarded to the referring hospital.[176]

135 The core of the case planning was the weekly Multi Disciplinary Team (MDT) meetings, otherwise known as 'ward rounds'. Dr Nelson and Dr McAuley held ward rounds, one on a Monday and the other on a Friday, in each case taking a full morning to discuss their patients' progress in detail with the nurses and other professionals. The meetings were attended by consultant psychiatrists, doctors in training, nurses, social workers, psychologists and a secretary to keep the minutes. When day patients were under consideration, professionals from the Royal Belfast Hospital for Sick Children were often in attendance. At times, teachers or members of the children's families also attended. Nurses, including juniors, were expected to participate in contributing their observations of the children during the previous week, but the responsibility for the children's treatment plans remained with the consultants.[177]

173 LIS 1199.
174 LIS 1198-1199.
175 LIS 094, 1199.
176 LIS 095, 484.
177 LIS 716, 1197-1198.

136 For the first three or four weeks children's presenting behaviours were assessed. The nurses who were the children's keyworkers sometimes made home visits, occasionally accompanied by a social worker or a psychiatrist.[178] Among the assessment methods used were interviews in which children were asked about the impact of their medication. About half a dozen professionals were present and children were questioned in groups of four or five.[179]

137 The MDT then formulated a care plan, and the length of a child's stay depended on the plan and its effectiveness. Among the witnesses who had been at Lissue, some stayed for about three months, and others about eight months; only two remained at Lissue for substantially longer periods.

138 There was a points system to encourage good behaviour which applied to most, but not all, children. HIA 38 wrote:

> "On our bedroom doors we each had a chart with stars or ticks for good behaviour. I think they were blue or red marks and points. At the end of the week they would give you a plastic toy if you were well-behaved. I did not get a toy very often."[180]

Children could earn a phone call for 750 points or trips to the swimming pool for 1050 points, but HIA 220 said that many children were too rebellious to earn such privileges.[181] Playing with the electric train set was a special reward and:

> "…you had to be extremely well behaved to get into that room. You were only allowed 10 to 15 minutes to watch the trains go round."[182]

The train set was laid out with scenery and the children's role was limited to using the controls to start and stop the engines.

139 As LS 81 noted, there were some medical problems which required treatment that might have been interpreted as abusive by another child who witnessed it but did not understand what was happening.[183] This chapter includes a number of examples. Children with oesophageal problems or anorexia, for example, had at times to be fed by nasogastric tube, and

178 Day 198, p.74.
179 LIS 050.
180 LIS 051.
181 LIS 026.
182 LIS 052-053.
183 Day 198, p.75.

if children being fed in this way tried to remove the tube they had to be restrained. Such action was, however, planned and intended as being in the children's best interests, as they were liable to die if they did not take in sufficient nutriment.[184] It is understandable that such treatment was misinterpreted when witnessed by other children.

140 There was a bell and buzzer system to treat children who were enuretics.[185]

The Management of Difficult Behaviour

Introduction

141 Lissue Hospital fulfilled an invaluable function, both in dealing with psychiatric problems, such as anorexia nervosa, and in coping with behaviour and conduct disorders which could not be managed elsewhere at that time in Northern Ireland, as there were no special social services units where younger children exhibiting severely disturbed behaviour could be contained.

142 There were three main types of misbehaviour which the staff had to address. Firstly, a number of children ran away. The staff searched the immediate locality, but if they could not find the children the police were contacted. It seems that most children who ran away were apprehended and returned fairly quickly. LS 69 told the police that when she was returned from running away she was stripped and sent to bed for two weeks, with no bedclothes, with the bedroom door locked and a member of staff sitting outside.[186]

143 Secondly, children climbed on the roof and threw roofing tiles at cars and passers-by frequently enough for there to be a protocol for managing such occasions – essentially a matter of talking the child down and discussing what had led to this behaviour.[187] Various people were to be informed. Dr McAuley also gave instructions that children who had been on the roof should be sedated and kept in their rooms incommunicado for 24 hours. If this process did not work, discharge was to be considered.[188] HIA 172 said that "plenty of kids" climbed on the roof and that he did so a number of times.[189]

184 Day 201, p.75.
185 Day 198, p.93.
186 LIS 30076.
187 LIS 1204.
188 LIS 166.
189 Day 197, p.112.

144 Thirdly, there was a variety of disturbed behaviour, involving fights with other children, for example, or damage to hospital property or disobedience. Some of the misbehaviour was petty, but some could have had serious consequences. HIA 251, for example, said in oral evidence that he had set fire to a barn at Lissue.[190]

145 Peer sexual activity or abuse does not appear to have figured as a major problem for the witnesses, except for LS 71 whose allegations in March 1983 have been described above. The *Stinson Report*, however, identified fourteen examples of children sexually abused by, or abusing, peers, and this was also the subject of some later complainants.[191]

146 In having to manage these types of disturbed behaviour Lissue Hospital was facing similar problems to those which staff in children's homes and training schools were having to address. Indeed some of the patients came from children's homes and returned to them after some months at Lissue, and some moved on to training schools. However, the methods for managing the behaviour of children at Lissue were quite distinct from those applied in other settings.

147 According to LS 79 there were no set rules for managing behaviour but LS 81 described the methods considered acceptable for dealing with difficult behaviour. She said that staff always intervened when there were altercations between the children, using a loud voice or eye contact, or inserting themselves physically between children to break up squabbles.[192] LS 7 said that staff always intervened in fights, first by talking to bring a resolution, but then by intervening physically if necessary.[193] HIA 3 also mentioned relaxation techniques he was taught to cope with panic attacks, which proved successful.[194] All of these practices were acceptable.

148 Corporal punishment was permitted in other settings in accordance with the Training School Rules and the Children's Homes Regulations, but it was not permitted at Lissue.[195] Although witnesses have complained of rough handling, there was no caning or slapping with belts. LS 81 said she never witnessed physical chastisement.[196]

190 Day 202, p.42.
191 LIS 12282-12283.
192 Day 198, p.94.
193 Day 201, pp.20 to 21.
194 Day 199, pp. 8 to 9.
195 LIS 095.
196 LIS 1205.

149 In some training schools there were secure rooms or locked intensive care units to isolate and contain children going through a disturbed phase. Lissue had no such facility, though staff did seclude children in their own bedrooms. Very rarely, if a child's behaviour was too disruptive to be managed at Lissue, s/he was discharged and "bumped back" to social services.[197]

150 Forms of discipline deemed acceptable in Lissue were time out, the use of medication, special observation, placing children in pyjamas, confining children to their rooms and losing privileges on the points system.[198] Witnesses made no complaint about the points system or special observation (except that there appears to have been minimal interaction between the patients and the nurses minding them). There were four main measures applied to deal with misbehaviour, however, about which concern was expressed by witnesses:

- holding and restraint;
- time out;
- wearing pyjamas in the daytime; and
- sedation.

These will now be addressed in turn.

Holding and Restraint

151 The guidance on restraint, dated January 1989, was issued immediately after the closure of Lissue, but assuming that it reflects earlier practice, it is noticeable that it applied essentially to the nursing of adults, and of the seven "commonly used methods" of restraint only sedatives and the "inappropriate use of night clothes during waking hours" were used at Lissue. The guidance noted that:

> "Restraint is only to be used where all other methods of management have failed".[199]

The guidance focused on general principles such as avoidance, clear communication, the use of minimum force and good recording; it did not give practical advice on ways of restraining children safely and with dignity.[200]

197 Day 201, p.74.
198 LIS 097-098.
199 LIS 160.
200 LIS 163.

152 Mary Hinds noted that it was the responsibility of the nurses to determine the approach to restraint, and a balance had to be maintained between care and control. It took a skilled nurse to restrain a child with compassion and kindness.[201] Staff were trained in ways of restraining children.[202] In order to de-escalate situations where a younger child was having a temper tantrum, nursing staff held children as "a firm but gentle response". The technique described was to approach a child from behind, holding their crossed forearms in an enfolding motion, while talking to them about what was distressing them.[203] This was intended to be calming and comforting, akin to cuddling, and it was contrasted with restraint. LS 81 said that she never saw anyone restrained. Indeed, she said that the best practice was to try diversion first, and she said she had at times been concerned that some colleagues placed children in time out as a first option.[204]

153 An older child requiring restraint would, LS 81 said, be placed in a part of the unit which offered them a safe space to regulate their own behaviour without placing themselves or others at risk.[205] Where an older child needed to be restrained, any younger children would be moved elsewhere to avoid causing alarm. If a child was unwilling to be moved, s/he would be held by the upper and lower arms with a staff member on either side and walked to the place of safety. LS 81 never witnessed pushing or grabbing.[206] According to LS 7, a younger child might be restrained on their bed, but older children were held down on the floor, with staff holding their arms and ankles until they calmed down.[207] Dr Nelson assisted in the restraint of one girl who went berserk and he injected her with paraldehyde, whereupon she settled down.[208] LS 7 denied that gloves had ever been used to restrain children.[209]

154 Staff witnesses denied the use of physical restraints,[210] but applicants gave accounts which seemed to reflect a genuine child's view of events.[211] HIA 421, for example, said that she shared a room with her brother. At first:

201 Day 200, pp.93 and 94.
202 Day 199, p.48.
203 Day 198, p.85.
204 Day 198, pp.86 to 87.
205 LIS 1203.
206 Day 198, p.89.
207 Day 201, p.18.
208 Day 201, p.19.
209 Day 201, p.30.
210 Day 201, p.61.
211 Day 196, p.24.

> "He was always trying to break and smash things, and trying to escape. I remember the staff tied [his] arms in a child's jacket to restrain him. He would kick out and scream hysterically."

HIA 421 likened the child's jacket to a mummy's bandages, wrapped round her brother so that he could not use his arms and could be picked up by staff. He took his anger out on her, but she was moved to a single room.[212]

155 HIA 251 wrote:

> "I don't remember much of my time in Lissue because I spent the majority of my time strapped to a bed. I remember the medical officers strapping me to a bed on several occasions and going out cold. They gave me injections."[213]

On one occasion he was upset when a member of staff kicked a Meccano motorbike which a boy and a girl had made to smithereens. This upset HIA 251 greatly and he was strapped in bed again, waking up the next morning.[214] In oral evidence HIA 251 repeated his allegation that he had been strapped down, and commented:

> "No one is going to turn round and say they hit kids down".[215]

He denied that gloves were used, but said his hands were strapped to the sides of the bed.[216]

156 Dr McAuley said that there was no training in restraint until the unit moved to Forster Green, but that the practice was to enfold smaller children in the arms and to hold older children on the floor.[217] Where possible, staff would "talk children down", but while some nurses were skilled in this, others were less capable of doing so.[218]

157 The Historic Case Review found two instances in their sample of children at Lissue being restrained. The records of the restraint emphasised the children's loss of self-control and the dangers that they posed to themselves and others, and the Board believed that restraint was necessary in such cases.[219] Restraint was recorded in the children's notes.[220]

212 LIS 070.
213 LIS 031.
214 LIS 032.
215 Day 202, p.13.
216 Day 202, pp.12-13.
217 Day 201, p.97.
218 Day 201, p.98.
219 LIS 096.
220 LIS 097.

158 The Board acknowledged that:

> "It is known, however, that restraints, including gloves which could be attached to beds and bedding, were used in very particular circumstances with very disturbed children. This would have been in cases where children may have tried to harm themselves, or remove clothing and this method was employed to try and prevent them doing further damage to themselves."[221]

159 We appreciate that the nurses had to deal with disturbed children who were at times at risk of harming themselves or others. The use of physical restraints such as straps or gloves attached to the children's beds is not mentioned in the guidance provided by the Eastern Board, and the denials by staff that such measures were used suggest that there was no authorisation for these means of controlling children. The descriptions are, however, compelling. **The occasions on which physical restraints were used may have been few, but their use was unacceptable; they would not have been used in other types of residential childcare, and their use in a hospital cannot be justified**.

Time Out

160 The main form of behaviour management was the use of time out. It was seen as a "break from the treatment programme", and in the nursing policy dated December 1986 it was specified that time out did not mean seclusion in a secure room, which was the subject of a separate policy document.[222] Undated guidance stated:

> "In most young children short durations [sic] of approximately five minutes are quite appropriate. However, in general the duration should not begin until the child is reasonably quiet…There is no excuse for extending the time or forgetting that the child is in time out."

If a child refused to go to time out, he was to be taken, and if he refused to remain in time out, he was to be restrained. Time out was not to start until the child was sitting or standing quietly, and if the quiet period was disrupted, the time out had to recommence.[223]

161 The basic procedure appears to have been that when a child was unruly he or she was escorted to a safe place such as their bedroom; if necessary a

221 LIS 582.
222 LIS 158, 159.
223 LIS 115, 161.

degree of force was used, for example holding the child by the upper arm to ensure compliance. Once in the place for time out, the child was asked to calm down, and when the child was "reasonably quiet", the "minute per year" rule was applied, such that a five-year-old had then to remain calm for five minutes before being reintegrated to normal activities. The purpose was not to punish a child, but was a means of de-escalating problematic behaviour, allowing the child an opportunity to reflect and self-regulate behaviour.[224] There was "no excuse for extending the time or forgetting the child [was] in time out".[225]

162 While it is understandable that practice may have changed during the life of Lissue, it was noticeable that each professional gave slightly different versions of the way that time out should have been applied, and the staff versions differed from the evidence of the applicants.

- Dr McAuley said that time out started when children were quiet and it amounted to two or three minutes for young children and five or ten for older ones.[226]
- LS 81 said that time out was for a maximum of 15 minutes for a thirteen-year-old, though the time could be extended to offer a calm environment to talk.[227] She also appears to have thought that the "minute per year" rule should have been applied as soon as the child was in time out, without waiting for the child to calm down, as there was a risk that time out could be extended unduly, though she herself never saw time out extended abusively for significant periods.[228]
- LS 21 could not recall the calculation of one minute per year, but said that time out applied while children were screaming and shouting, with five or ten minutes as a maximum. Children were told, "When you settle, it's all over."[229]
- LS 7 wrote of children being calmed by being made to stand in a corner for three minutes or placed on their bed by staff if they did not comply.[230]

224 LIS 1200-1201.
225 LIS 1217.
226 Day 201, p.99.
227 Day 198, p.105.
228 LIS 1200.
229 Day 199, p.50.
230 LIS 1391-1392.

163 It is possible that practice changed over time or that witnesses' memories were faulty, but in dealing with disturbed children it is important that staff should be consistent, so that children who misbehaved knew exactly where they stood and knew that they could not manipulate staff. If practice were as variable as the evidence suggested, it could have appeared arbitrary and have left children feeling confused rather than secure.

164 HIA 172 provided an example of the proper use of time out. She said that LS 73:

> "...made the place much easier. Even when [LS 73] was being strict and punishing you by putting you in time out she was fair and did what she said. If she told me I was going to my room for five minutes, then I was put there for five minutes. I respected her and she was kind."[231]

165 By contrast, five witnesses complained that they were left in time out for prolonged periods. They also saw time out as punitive on occasion. HIA 220, for example, said:

> "One time I was thrown into the cupboard and locked in the dark. I do not know how long I was in there for. I hated the dark. Whenever I was at home my mum kept my bedroom door open and landing light on ..."[232]

HIA 421 said she was left in her room all day sometimes and she refused the food which was brought to her.[233]

166 HIA 172 wrote:

> "...you could be left for quite a long time. I think some of the staff over used time out so they did not have to deal with us. Sometimes they would strip you and put you into bed. You could be left for the rest of the day or until the next mealtime. If you resisted you were manhandled. If you fell asleep because you had been left for so long and then couldn't sleep that night you were punished again for not going to sleep."

167 HIA 172 went on to say that he started to hallucinate, but thought that this could have been the impact of the medication he was given.[234] In oral evidence he added that he was separated from the group and supervised

231 LIS 011-LIS012.
232 LIS 026.
233 Day 196, p.34; LIS 071.
234 LIS 009.

one to one in his room "on observation", but that this did not constitute individual attention, as the member of staff sat at his door to ensure he did not leave. At other times he was left sitting on the toilet for long periods as a way of dealing with his soiling, or in the bathroom.[235]

168 HIA 38 said that he was occasionally locked in his room and denied supper for misbehaviour such as walking too fast on the corridor or pushing the lift button. On one occasion he ran into the video-recording room, and as a punishment he was locked in his room for three days during association time when the children had the chance to play.[236]

169 HIA 251 was put in isolation when a story circulated that he had set fire to a hedge and had burnt hedgehogs. This later proved to be untrue and Lissue staff apologised for placing him in isolation.[237]

170 LS 81 was concerned that time out was implemented without the prior use of diversionary techniques which could have precluded the need for time out.[238]

171 Seclusion was defined in an EHSSB policy document dated December 1986 as:

> "…the social isolation of a patient in a locked room on his/her own which he/she is unable to leave of their own volition".[239]

Seclusion had to be authorised by a doctor, and neither Dr McAuley nor Dr Nelson recalled patients at Lissue ever being locked up.[240] Seclusion was to be used for 24 hours if a child climbed onto the roof, but a member of staff had to stay with the child in his/her room.[241]

172 LS 81 said that doors were only locked briefly when an absconder was returned by the police until the situation had de-escalated. Indeed, there was debate as to whether doors should be shut, and practice was changed such that doors were left open, so that children did not feel closed in.[242]

173 The practice of applying time out was - and still is - acceptable in childcare as a means of calming a disturbed child. If applied properly it can be

235 Day 197, pp.97 to 99.
236 LIS 050.
237 Day 202, p.15.
238 LIS 1200.
239 LIS 114.
240 LIS 114.
241 LIS 115.
242 LIS 1204.

very effective. The volume of detailed evidence offered by the witnesses suggests that the policy was applied in different ways by different nurses, and that at times children were left in their rooms for excessive periods of time, perhaps locked in, and sometimes missing not only schooling or association with other children but also meals. **While the policy was not at fault, the implementation of time out was not always in accordance with the policy and constituted systemic abuse**.

Pyjamas

174 HIA 172 wrote of a variation on time out:

> "Sometimes I was punished by being made to wear my pyjamas all day and not sent to school. I used to sit in a room on my own all day looking at the pages of Ceefax. I was left school work to do but was unsupervised."[243]

The fortnightly summary of HIA 172's progress dated 17 May 1985 commented:

> "Has spent much time on a one to one basis and has been kept in isolation most of the time. But when he was on group activity, [HIA 172] participates very well, for a short time only."

Most other observations recorded his difficulty relating to staff and peers.[244]

175 HIA 251 was also at Lissue in 1985. His main memories are of being medicated and confined to his room:

> "I was kept in a room by myself and was very rarely allowed out to mix with the other children. I can visualise the corridors but I cannot remember where the rooms were as I was kept in my room most of the time. I know the staff office was right beside me so they could observe me. The door was always kept open and I could see out."[245]

176 HIA 251 was also made to wear pyjamas as a daytime punishment; indeed, he even attended the school wearing them. He was told that he had to "earn back his clothes".[246] On another occasion he was put in pyjamas when he was sent to bed early.[247] Allowing for the passage of time leading to some possible exaggeration, the impression which HIA 251 conveyed of being confined to his room was persuasive.

243 LIS 008.
244 LIS 1304.
245 LIS 031.
246 LIS 618, 620-621, 628, 636.
247 Day 202, p.16.

177 HIA 251 ran away frequently and twice he climbed on the roof, doing considerable damage.[248] His behaviour would therefore have posed serious problems to the staff. Indeed Dr McAuley had to issue instructions on the way in which further incidents of this sort should be managed, including tranquillising the child as soon as he came down from the roof.[249]

178 LS 81 said that the use of pyjamas to prevent further absconding was rare.[250] The Health and Social Care Board stated that the wearing of pyjamas all day was "an accepted form of discipline within the context of behaviour modification".[251] The purpose of making a child wear pyjamas in the daytime was presumably two-fold: as a punishment for a transgression, such as running away, and as a deterrent from further absconding, since he would not want the humiliation of being seen in public in night clothes. There were risks that the prolonged threat of humiliation would lose its impact, and that the implied humiliation did not provide a good basis for staff to develop a closer working relationship with the child. Indeed, the guidance on restraint refers to the "inappropriate use of night clothes", suggesting that this measure did not have the Eastern Board's backing.[252] While the practice could not be termed abusive, in other forms of residential care at that time it would have been seen as poor childcare practice.

Sedation

179 The evidence we have received in the course of this Inquiry suggests that very few children in children's homes and training schools were prescribed sedatives as a planned way of calming their behaviour, whereas witnesses who were resident in Lissue spoke of its frequent use. Furthermore, we have found no evidence at all of children in children's homes or training schools being injected in a crisis to calm them down, whereas four former patients said that they had experienced this in Lissue.

180 LS 66 did not give evidence to the Inquiry, but when reporting allegations of abuse to the police in 1993 she referred to being injected in the hip by a nurse, LS 78, as a means of control.[253]

248 LIS 628-631, 641-647, 651-654.
249 LIS 633-634.
250 Day 198, p.119.
251 LIS 1213.
252 LIS 160.
253 LIS 279.

181 HIA 38 said he was given Largactil every night, plus two Ritalin tablets every day, plus fortnightly injections by a nurse, LS 7. He feels that as a nine-year-old he should not have been given such drugs.[254] He said that he was also introduced to smoking to calm him down.[255] He quoted his father as saying that he was:

> "always lethargic and tired like a zombie, and not the hyper [boy] that went away".[256]

HIA 38 said that he was given drugs "willy-nilly", as were other children.[257] In oral evidence he said:

> "...we were injected all the time....I was always apprehensive, so I was. There is nothing fun about being sat on and having your rear end injected, so there is not, and that was it. You didn't know anything else till next morning."[258]

182 He felt that he:

> "...should never have been given such medication as my medical records show that I had no signs of mental illness."[259]
>
> "If you were very badly behaved, the staff threatened you with an injection and if you were difficult to control they held you down, usually by sitting on you, and gave you an injection in your rear to sedate you. It was the scariest thing in the world to me."[260]

HIA 38 provided the Inquiry with leaflets concerning his campaign to take legal action against the responsible authorities who, he feels, destroyed his life by placing him in institutions.[261]

183 HIA 172 wrote:

> "On one occasion I locked myself in to the observation room. The staff eventually talked me round and I let them in. When I was opening the door they threw water over me, pinned me to the floor and knocked me out. They pulled my pants down and gave me an injection."[262]

254 Day 198, p.5.
255 LIS 049.
256 LIS 053.
257 Day 198, p.
258 Day 198, p.7.
259 LIS 049.
260 LIS 050.
261 LIS 058.
262 LIS 009.

When he woke up, having been sedated, he found Lego, biscuits and snacks by his bed, which he recalled as being most unusual.[263] HIA 172 gave a similar account of this incident to the police in 1993.[264] He did not see the abuse he alleged as being institutional, but as the behaviour of individual staff.[265]

184 HIA 172 was recorded as having been injected with 5 mg of Valium on only one occasion, on 6 May 1985, when it was administered by Dr McCune, who was assisted by a security man, and the reason given was that HIA 172 had wrecked his bedroom. The chart of his sleep pattern showed that HIA 172 was running wild round the grounds until about 1am.[266] Dr McCune also prescribed Melleril syrup orally four times a day and further Valium immediately "if necessary", though on the injection record form it was noted, "If need to repeat, phone first".[267] This presumably authorised nurses to undertake the injection in the absence of a doctor, but after consultation.

185 HIA 251 said he was strapped to his bed on several occasions, when he went "out cold". He wrote:

> "They gave me injections. I could have been under for days and in that time I don't know what they were doing to me. There was a large mirror in my room and I must have been observed by the medical officers. I was given injections regularly and I do not know how long I was sedated for…I feel the injections had a negative impact on my life."[268]

The records confirm his recollections.[269] HIA 251 attributed his later drug dependency in part to the injections he had at Lissue, as they messed his head up. While acknowledging that he had behaviour problems, he did not feel that strapping him down to his bed and sedating him was the correct treatment.[270]

186 After one of HIA 251's escapades, Dr McAuley telephoned the senior nurse who made notes of the call:

> "…after child was returned to unit that child was being given tranquilliser to relieve Nursing pressure not given as a punishment for being on the roof, he asked that Nursing Staff were not to be negative towards the

263 Day 197, pp.130 to 131.
264 LIS 31222.
265 Day 197, p.94.
266 LIS 1350.
267 LIS 1340, 1343.
268 LIS 031.
269 LIS 646, 649.
270 LIS 036.

> child, but having said that, said child was to earn all his priviledges [sic] back as he earned them (by positive behaviour) I informed Dr McAuley that Nursing Staff were not negative but other disciplines had done nothing re arranging visits from Mum and Dad as had been promised previously and child had little positive to look forward to also child was very immature socially".[271]

187 This phone message indicates not only that HIA 251 had been injected to relieve pressure on the nurses, rather than as a part of his medical treatment, but that there were tensions within the multi-disciplinary team, perhaps caused by the demands which HIA 251 had placed on them. The boy, meanwhile, was sleeping with his thumb in his mouth.[272]

188 The HSCB suggested that:

> "... this note should be read in the context of the evident risk posed by the behaviour of HIA 251 to himself, other patients and staff on the Ward. By administering a sedative, those risks would be reduced and the Ward would be brought back under control."[273]

There is no suggestion in the records that HIA 251 was stirring up other children to misbehave. His behaviour was certainly a severe nuisance and there was a risk of danger to people nearby when he threw tiles and other items from the roof, but there was no need to bring the ward under control. When HIA 251 came down from the roof the sedative controlled his misbehaviour at that time, but it would have done nothing to help him understand or control his own behaviour in the longer run.

189 We have already quoted Dr McAuley's instructions that children who went onto the roof were to be sedated when they came down. The fact that this was a general instruction suggests that it was a measure to control the children rather than a specific decision concerning the medical needs of an individual child. It can, of course, be argued that each individual child needs to be calmed and settled, but the dividing line between the two justifications needs to be scrutinised carefully if malpractice is to be avoided. (In the 1980s there were instances in England where the excessive use of sedation to control disturbed adolescents led to allegations of serious abuse.)

271 LIS 649.
272 LIS 649.
273 LIS 80047.

190 Dr Nelson said that children were usually given mild sedatives in tablet or liquid form; injections were rare.[274] Except at night there was always a doctor on the premises at Lissue, and staff who provided evidence were clear that sedation was only applied if prescribed by a doctor.[275] Certainly this was the proper procedure. During the working week there was a senior registrar on site who was in a position to authorise injections in the event of emergencies. Dr McAuley said that medication was written up on a Kardex, that the nurses did not give injections, but the registrar, who was there throughout the working week, could have done so.[276] Dr Nelson, however, accepted that on occasion nurses might give injections.[277]

191 LS 21 said that the safety of the staff and children was of paramount importance, and that, as long as sedation was part of the child's plan, he would not have needed approval from a doctor on the spot before injecting a child.[278] LS 7 said that in her seventeen years in the unit she only recalled one child having injections, which were administered by Dr Nelson.[279] From the evidence provided by the witnesses we consider LS 7's memory to be at fault.

192 These different perceptions suggest that, perhaps at different times, there was flexibility in practice. Such treatment should only have been administered in the individual child's best interests, but the evidence suggests that on occasion children were sedated to make the nursing task easier.[280] It is clearly a matter of medical judgement to determine whether a child requires sedation in his or her best interests, but the drugging of children to make the job easier for nurses or to retain control of the ward is clearly outwith normal medical decision-making.

193 It seems that the use of sedation in the form of syrups and tablets was probably fairly common, and that injections were unusual but not rare. It appears that injections were usually, but not always, administered by doctors, and that nurses were at times authorised to inject children as necessary. While acknowledging that the nursing staff faced a very demanding task in dealing with disturbed children presenting difficult behaviour, the use of drugs to control children remains an unacceptable practice. **On the occasions when children were sedated to render**

274 Day 201, p.146.
275 Day 198, pp.119 to 120.
276 Day 201, pp.100 to 101.
277 Day 201, p.146.
278 Day 199, pp.45 to 47, 89 to 93.
279 Day 201, pp.8, 19.
280 LIS 649.

the nursing task easier, the use of injections constituted systemic abuse.

Allegations of Abuse

Physical Abuse by Staff

194 The only witness to make allegations of abuse at Lissue during its early years was HIA 404. He was admitted when he was very young with a history of multiple illnesses and he came from a family where tuberculosis was rife; indeed, an aunt who cared for him died of it while he was in Lissue. HIA 404 himself was later found to have scarred lung tissue. His main complaint was that he was cold; the windows were open and it was "cold like a dungeon".[281] Since one of the treatments for tuberculosis at that time was placing patients in the fresh air, this could account for his treatment.

195 He recalled a nurse who shook him and beat him and threw him down on his cot mattress until another nurse remonstrated and comforted him. HIA 404 was also hit with a dessert spoon by nurses who were trying to feed him, as he had difficulty eating.[282] He also remembered a male nurse who exposed himself, but did not recall any sexual contact. There is no reason to doubt HIA 404's account of his experiences but as he was so young it is not altogether clear that the incidents occurred in Lissue. When he eventually told his mother of the abuse she was astonished, as she had seen Lissue as a sanatorium in the countryside, providing the best possible care.[283] As HIA 404 is the sole witness from that era we cannot conclude any finding of systemic abuse.

196 The section above on the management of difficult behaviour has included examples of rough handling of children. HIA 421 was at Lissue in the mid-1970s. She said:

> "The staff were very physical and rough. They pulled me by my arms and my hair and trailed me down the stairs. I was shoved, dragged and thrown into my room and locked in on several occasions. It was an awful place to be in."[284]

281 LIS 065.
282 Day 196, pp.18 to 19.
283 Day 196, p.13.
284 LIS 070.

197 HIA 241 said she was aware that her behaviour was challenging and for a five-year-old she was strong and aggressive; it took two or three staff to pin her to the ground and at times the weight of staff on her made her sick.[285] She said she also saw children dragged along the floor into their rooms by their arms and being restrained.[286]

198 HIA 38 said that LS 7:

> "…had a pick on me from day one. On occasions she grabbed me by the scruff of the neck and she was rough with me and other residents."[287]

Although LS 7 could be "quite nice" if he conformed and "acted like the robot she wanted you to be", HIA 38 saw her as "evil".[288]

199 That informal physical punishment was used, appears to have been confirmed by a staff observation of a play session:

> "[HIA 38] seems to watch staff through play as if he was afraid of doing something wrong or turn his back in case he would get a slap, very edgy."[289]

200 HIA 220 found all the nurses very strict, and provided examples of physical abuse. When he was feeling unwell and felt unable to eat his dinner LS 22 hit him on the side of the face and knocked him to the floor for wasting good food. On another occasion when he got excited and was rushing round the room LS 23 told him to stop and when he ignored her, she took him to a bathroom beside the TV room and rubbed soap on his tongue until he vomited.[290]

201 HIA 220 said that when he and another older boy absconded they were caught by LS 21 and LS 27; he alleged that he was put in a bath of ice cubes and thrown into bed while still soaking wet and freezing, such that his bed was wet the next morning.[291] LS 21 denied the allegation, saying that he was never successful in catching absconders, and that they were always returned by the police or the Army.[292] The records, however, indicate that LS 21 did return HIA 220 to Lissue after he had absconded.[293] [294]

285 Day 196, pp.27 to 28.
286 LIS 070.
287 LIS 050.
288 LIS 052.
289 LIS 051.
290 LIS 025.
291 LIS 026.
292 LIS 60519.
293 Day 199, pp.69 to 70.
294 LIS 1182.

202 HIA 220 said that he saw another child, LS 14 being abused by being force-fed through a funnel.[295] LS 21 suggested that the allegation was "complete fantasy"[296] but from other evidence it is our opinion that HIA 220 probably witnessed LS 14 being treated for anorexia, and that he was being fed by tube as it was vital that the child should gain weight. Such a process could have appeared to be abusive to a child who did not understand its purpose.

203 HIA 172 told police of an occasion when he was misbehaving and was dragged down a corridor and put to bed forcibly by three nurses, who covered him completely with a quilt until he quietened down.[297] This practice was also noted in the Stinson Report. In oral evidence HIA 172 said that for confinement purposes in the daytime a bed in the dormitory next to the dining room was used; children were stripped, put under a quilt and then thumped by staff.[298] Staff witnesses have denied that this happened.

204 HIA 172 said that one night he climbed out of a window, ran around the grounds in bare feet, climbed in through the kitchen window and took a tin of biscuits. He was about to go back to bed when LS 8 grabbed him by the hair, dragged him along the corridor and up the stairs and flung him into his bedroom, such that his head hit the low windowsill. HIA 172's mother visited the next day but did not remonstrate when LS 8 denied hurting him and said that the boy had caused the bump on his head himself.[299]

205 By contrast, it is clear from records that staff attempted to be accommodating to HIA 172's behaviour by approaching him positively and trying to avoid triggers to disturbed behaviour.[300]

206 HIA 119 was placed at Lissue in 1983, and said he was:

> "…subjected to physical and mental abuse on a daily basis by three members of staff: LS 34, LS 7 and a man called LS 35. The abuse started a couple of weeks after I arrived."

207 Staff whom he considered to be nice did not intervene, but comforted him and told him he would be all right. He alleged that he was slapped, kicked, nipped and verbally abused, identifying LS 7 as the worst abuser. He found

295 LIS 025.
296 LIS 60520.
297 LIS 31220.
298 Day 197, p.80.
299 LIS 011, LIS 31221.
300 LIS 1323.

slapping round the legs very painful; if caught talking at mealtimes he was pulled from his chair by the ear and sent to his room without anything to eat. Sometimes they were locked in their rooms.[301] He said that every day he was treading on egg shells in fear of being beaten.[302] He was kicked or slapped by staff when they passed in the corridor.[303] HIA 119 said that he also saw other children physically abused.[304]

208 HIA 119 recounted a specific incident in which LS 35, a nurse, had stamped on his hand several times while playing football. Being in pain, he complained and was taken to Lagan Valley Hospital where a hairline fracture to one of his fingers was identified. He was told to say it was an accident.[305] On another occasion LS 35 spun a roundabout so fast that HIA 119 fell off and broke his wrist. Again, he was told to tell the doctor it was an accident.[306] LS 35 has not been identified. There are confirmatory records that HIA 119 was taken to casualty on 11 July 1984 for an injured finger and on 22 July 1984 for an injured wrist.[307]

209 HIA 251 alleged that he was hit on several occasions by a member of staff who also taunted him when he wanted a cigarette. He felt that it was as if the member of staff was "playing mind games" with him, perhaps to make him react by running away.[308] [309] Another incident which had made a great impression on him was when he absconded and the "gateman" caught him and pushed his face in a puddle until two policemen and a member of staff pulled the gateman off.[310]

210 HIA 3 complained of physical abuse, as the staff grabbed him and pushed him to get him to do what they wanted. They were physically rough, grabbing his shoulders and the back of his neck. One "cocky" member of staff punched and shook HIA 3 any time that they met.[311] He felt that there was little care or understanding. One night when he was unsettled he got up and walked around; the staff shouted at him, grabbed him by the shoulders and put him back to bed.[312] This evidence is in contrast

301 LIS 002.
302 LIS 003.
303 LIS 004.
304 LIS 003.
305 LIS 002.
306 LIS 003.
307 LIS 970, 1024.
308 LIS 032.
309 Day 202, p.43.
310 LIS 033.
311 LIS 043.
312 LIS 045.

with some of the records, which describe the way that staff tried to help HIA 3 settle at night and taught him how to use relaxation and breathing techniques to counteract panic attacks.[313]

211 With one exception,[314] the physical abuse which was alleged was all in response to difficult behaviour which staff were attempting to control. There is no doubt that the work was difficult and the children's misbehaviour was challenging and at times exasperating, but the blank denials by all staff concerning any form of excessive reactions to the children are not convincing in the face of the detailed evidence of the former patients. It may well be that the incidents which rankled with the former patients have been forgotten by the staff. **It is our opinion that at times some staff did overstep the mark and were unduly rough in their treatment of the children, and that this constituted systemic abuse**.

Sexual Abuse by Staff

212 HIA 426 suffered from chronic bronchial asthma and he attended Lissue from 1968 to 1971, before the psychiatric unit was opened. His only allegation is that a male nurse, LS 9 regularly took him to a part of the hospital that was little used and masturbated him. He said that he was pinned against a wall in a corridor and abused, "not aggressively, but tenderly". HIA 426 was discharged but re-admitted the following year, and the abuse recommenced.[315]

213 HIA 294 was admitted to Lissue Hospital around 1969 for the treatment of an eating disorder and encopresis. He said that he was put on his stomach and could not see the faces of staff. "And there was someone down below and I don't know if I was or if I wasn't…But I can remember the same thing happening to some other wee boy, the same cries." This made him feel "very dirty".[316] It is our opinion that the incident was probably some form of treatment for HIA 294's encopresis, rather than sexual abuse, and it is understandable that, if HIA 294 did not understand what was happening, he found the incident sufficiently upsetting to be memorable.

214 HIA 220 alleged that he had been sexually assaulted by LS 21 on a number of occasions. He recalled that on the first occasion he was "attacked", LS

313 LIS 721, 730, 737-738.
314 LIS 004.
315 LIS 038.
316 LIS 060.

21 took him to his dormitory, locked the door, said that he was HIA 220's friend, and rubbed his hands up and down his legs, touching his genitals. On the second occasion LS 21 was more violent and he raped HIA 220, saying that this was their "little secret". HIA 220 said that this continued two or three times a month until he left Lissue.[317]

215 HIA 220 said that he knew that other children were being abused, but they did not speak of it and kept themselves to themselves, not being "outward".[318] He felt that other staff were aware of what was happening but turned a blind eye to it.[319] LS 21 denied these allegations, pointing out that the bedroom doors had glass panels and the bedroom was very close to a busy office, so that any abuse would have been readily visible.[320]

216 HIA 220 also recounted an incident in which he was lured to an arts and crafts room to play with a new train set. He alleged that the door was locked, and that he was raped on a bed not only by LS 21 but also by a second member of staff, LS 27, while he was made to perform oral sex on LS 21 and masturbate a third member of staff, LS 26. Neither of the additional abusers, about whom HIA 220 provided further identifying information, touched him again.[321]

217 LS 21 denied the allegations against him, stating that he had tried to live his life by Christian principles and found the allegations "distasteful and disgusting". He said that the only craft room was very small, had no bed and would have had painting materials in it.[322] HIA 38 said that the room with the train set was next door to the interview room. LS 21 also denied that there were workers at Lissue called LS 27 or[323] LS 26, suggesting that they were "a complete concoction".

218 HIA 220's account of this incident is unique among the allegations of sexual abuse at Lissue. It is the only one involving more than one abuser, and it would have entailed discussion between the three staff beforehand and forward planning in the siting of the bed in the hobbies room. Neither LS 26 nor LS 27 has been identified from any HSC records.[324]

317 LIS 31282-31283.
318 Day 197, p.13.
319 LIS 024.
320 LIS 60520.
321 LIS 024, 31001, 31283-31284.
322 LIS 60518-60519.
323 LIS 052.
324 LIS 1159.

219 The allegations described here were provided by three of the witnesses, but a number of other former patients came forward later, alleging sexual abuse. Some of their allegations are described in the section below on *Allegations 1993-2008*, suggesting that LS 79 abused patients.

220 Our conclusions are that HIA 426's account is persuasive, but appears to relate to a single member of staff, while HIA 294 may well have mistaken medical treatment for possible abuse. In neither case could their experiences be termed systemic abuse.

221 HIA 220's accounts refer primarily to LS 21, and it is perhaps significant that two female former patients, LS 66 and LS 69, also named LS 21. He strongly denied all abuse, and in oral evidence he said that he had been informed that he would not be prosecuted, having received a letter (in August or September 2015, he thought) to advise him that no further action was to be taken against him.[325] We did not find LS 21's evidence persuasive.

222 **We accept that some patients were sexually abused and consider this to have been systemic abuse**.

Emotional Abuse by Staff

223 HIA 421 was aged five when she was admitted to Lissue. She came from an abusive home where her mother was violent towards her and prior to admission she had suffered burns, beatings, broken limbs and dysentery, but she found no respite at Lissue. Looking back she said:

> "I cannot remember how long I stayed in Lissue but I do remember it was a horrible place. It was very strict and there was no care or affection from the staff. I remember lots of children crying and screaming all the time. It seemed like nobody cared that the children were unhappy. It was a cold and frightening place."[326]

224 HIA 172 wrote:

> "There were three types of people working in Lissue: the gentle and kind people, the neutral people and then the vicious people. The latter were bullies who seemed determined to humiliate and punish at every opportunity as they were disinterested [sic] in the children. ...There was no humanity in the care they provided and I was deprived of any motherly love."[327]

325 LIS 60515.
326 LIS 070.
327 LIS 009.

225 In a contemporaneous summary of his case, dated 23 July 1985, Dr McCune made the point that HIA 172:

> "...seemed to thrive in one to one situations with lots of affection, which he got from both teaching and nursing staff". [328]

He also "revelled in praise" and responded in his schoolwork by applying himself better, taking great pride in completing tasks.[329]

226 HIA 172 provided two examples of emotional abuse. When his mother left after a visit, he was upset and cried, watching her out of the window, and a nurse, LS 6 told him that his "mum didn't love [him] and to shut up and stop crying".[330]

227 He said that on the second occasion he had made a pair of trousers out of a white sheet and LS 7 embarrassed him by making him parade up and down the corridor in them, revealing his genitals.[331] It should be noted that her version of the incident is quite different. She said that, because the other boys were wearing shorts, HIA 172 had cut down a pair of trousers to the point where they were indecent, and she had a battle with him to insist that he wore a more presentable pair.[332] [333]

228 HIA 172 said:

> "[LS 7] made it her mission to punish me as frequently as she could. I could not step out of line or make any sort of mistake when she was around or I would be put in my room or standing with my nose in the corner...I wasn't the only one; there were lots of other kids you know, and most of them probably haven't come forward because most of them don't want to go through this, don't want to hear or read about how they are denying what they did to kids."[334]

229 Other than physically rough handling, the main concern of HIA 3 was that staff made fun of him and attempted to belittle him and his family. HIA 3 was concerned that he might have suffered a brain haemorrhage and was very anxious, and he said that one member of staff made fun of his problems, saying things such as, "Is your head still on your shoulders?" HIA

328 LIS 1318-1319.
329 LIS 1319.
330 LIS 010.
331 LIS 010.
332 LIS 1395-1396.
333 Day 201, pp.30 to 32.
334 Day 197, pp.103 to 104.

3 found the taunting distressing. He witnessed the same man mimicking a boy with Tourette's syndrome, which annoyed and depressed him.[335] [336]

230 The nurses' records noted:

> "[HIA 3] unable to share a joke with his peers and staff, he likes to sit and have a laugh at other peers but doesn't like the joke to be on him. Tonight staff teasing him and he was unable to take it, ran out of the room and began to cry, when spoken to firmly he settled quickly."[337]

Dr McAuley was clearly shocked when this entry was drawn to his attention and expressed his concern.[338] The HSCB have acknowledged that such teasing was inappropriate.[339] It is our view that if a child is as fragile as HIA 3 was at this time, it was unprofessional to tease him. **We consider this to have been an instance of systemic abuse**.

231 When family therapy sessions were held, the staff asked HIA 3 and his family questions which he found belittling, degrading and humiliating, for example about his sexuality. His brother walked out on one occasion, though his parents trusted the professionals and never queried the line of questioning.[340] [341] LS 21 said that he would never have asked a child about masturbation and doubted whether the psychiatrists would have done so either.[342] Clearly the professionals involved would have had reasons for asking questions, despite any discomfort they caused, and we are not in a position to form an opinion on what was part of HIA 3's treatment. Even though he was only there for three months, HIA 3's perception was that his life had been ruined by Lissue.[343]

232 There were witnesses who felt that their experiences in Lissue had been seriously damaging. HIA 220, for example, had wanted to be an airline pilot, and he said that while others might consider his aspirations laughable, his dream never came true because his whole life had been "totally destroyed" by Lissue. He pointed out that others who had been through Lissue Hospital had committed suicide or taken to drugs.[344] HIA

335 LIS 043.
336 Day 199, pp.6 to 7.
337 LIS 758.
338 Day 201, p.123.
339 LIS 80036.
340 LIS 044.
341 Day 199, p.15.
342 Day 199, p.55.
343 LIS 045.
344 Day 197, pp.39, 43.

3 felt that Lissue had failed him; while his brothers and sisters had all obtained degrees at universities, he had no qualifications, and in his twenties had turned to alcohol and was not confident socially.[345]

233 In the Stinson Report, out of a sample of 34 case files, eleven instances of humiliation were identified in which:

> "Children were reduced to their most vulnerable state, i.e. having their dignity taken from them,..."

for example in strip searches, at bath time or when on the toilet.[346]

234 The examples above include specific instances which children found hurtful as well as generalised judgements that some patients had found their time at Lissue damaging. The records also indicate times when staff were trying to be supportive and sensitive to the needs of children who had had difficult times prior to admission. **It is our conclusion, however, that there were many instances when staff were unfeeling and failed the children who required their support, and that these shortcomings were sufficiently frequent to be deemed systemic emotional abuse**.

Unacceptable Practices

235 HIA 421 was admitted to Lissue in 1976 and she described aspects of childcare practice which were poor, though some fell short of being abusive. She wet the bed and she said that the staff refused to change the sheets, but left her in wet underwear for days. She was very sore, and when she complained, she was dragged into the bathroom and thrown into a cold bath with disinfectant, such that her skin was "roaring red". She was left freezing with no towel. As she was a constant bed-wetter, and since the sheets were not changed and smelt appalling, she often had to sleep on the floor. She did not sleep properly and was tired during the day.[347]

236 In a case review report in 1986 it was noted that HIA 421 had "a total disregard for her personal hygiene".[348] HIA 421's treatment for enuresis as described was clearly unacceptable. The HSCB say that they do not accept HIA 421's account of her treatment.[349] While the frequency of such treatment may be open to doubt, we accepted her account of events.

345 Day 199, p.26.
346 LIS 12289.
347 LIS 070-071.
348 LIS 1148.
349 LIS 80026.

237 HIA 172, who was admitted to Lissue in 1980, was also regularly enuretic and put in a bath containing Dettol. He said:

> "The staff did not want to touch me and it made me feel like I had a disease. I felt I was being sterilised in the bath and I found it quite upsetting."[350]

238 HIA 421 also alleged that if she refused to eat food it was left till she ate it, and she added that morning times were mayhem, with children screaming and banging at the table.[351] This could have been before LS 21 introduced the morning meetings, which he said made daytimes much calmer.

239 HIA 172 also said he was punished for not eating his food:

> "I remember a member of staff putting me in a room with a bowl of cold peas and telling me I was not allowed to leave until they were finished. I put them in my mouth and then ran to the toilet to spit them out. I think this is an example of the pettiness and inhumane treatment by the staff."[352]

There is written evidence, however, that HIA 172 had eating problems and that his behaviour modification plan was designed to help him eat in an acceptable manner, as he had been using his fingers, cramming his mouth and spattering his food over everyone.[353]

240 LS 7 wrote that children were encouraged, but not forced, to eat:

> "A child could not be pandered to and there was a set diet. Certainly a child would be encouraged to eat, with the admonition if they did not eat then what was put in front of them, that there was no further food going to be available at that sitting."[354]

241 During police enquiries, HIA 172 accused LS 7 of squirting lemon juice into the mouth of a little girl.[355] She explained that this was part of a treatment plan authorised by Dr McAuley; the child had great difficulty masticating and swallowing and it was thought that the lemon juice might act as a stimulant to eat other food. The girl eventually required surgery to correct her swallowing reflex.[356]

350 LIS 008.
351 LIS 071.
352 LIS 008.
353 LIS 1280.
354 LIS 1394-1395.
355 LIS 31144.
356 LIS 1396.

242 HIA 421 said that children were not allowed to talk and communication was not encouraged, so that they never bonded.[357] She was described in her case review as "glum and unsmiling" and having "very low self-esteem".[358]

243 Some of the examples given above describe poor childcare practice, but they appear to be isolated examples rather than consistent systemic abuse.

Staff Responses to Allegations

244 All the members of the nursing staff against whom former patients made allegations have consistently denied all accusations. A number also stated that they had not seen any colleagues assaulting children either. LS 81, for example, acknowledged that some of the older staff were "firmer", including LS 7, but she also described her as being "compassionate".[359] She said that guidance, not force, was used when children were placed in time out, and that staff tried to be supportive rather than coercive.[360]

245 The allegations which LS 7 faced were both general and specific, but they all related to rough handling of children. LS 7 denied all the allegations unequivocally:

> "I refute all and every such allegation from the most minor, to the most serious."[361]

She said that she enjoyed her entire time at Lissue, and believed that her work had been valuable, with positive outcomes.[362] She said that the method of creating an orderly atmosphere was to make a child stand in a corner for three minutes, and if that were insufficient, to take the child to his/her room and place the child on the bed. She found all the children "engaging to varying extents" except for one, who was "a deceitful bully".[363] LS 21 said that LS 7 was "very competent" and he had recommended her upgrading.[364]

357 LIS 071.
358 LIS 1148.
359 Day 198, p.101.
360 Day 198, p.102.
361 LIS 1391.
362 LIS 1398.
363 LIS 1392.
364 Day 199, p.42.

246 As noted in para. 211, in view of the volume of detailed evidence provided by the complainants, we found the denials of the staff unpersuasive.

Abuse by Peers

247 HIA 38 said that he was "beaten by other children almost daily", and pointed out that the records indicated that staff were aware. He felt that the records suggested that staff did not intervene, and the tone of the records:

> "...would suggest that the staff thought I deserved the beatings."[365]

The Health and Social Care Board argued that staff were concerned that HIA 38 brought out the worst in his peers, niggling them to the point that he required protection.[366] The incidents to which HIA 38 referred were clearly not covert bullying, but part of the open misbehaviour of the children.

248 As described above, LS 71 alleged three instances of buggery by an older patient. Dr McAuley questioned whether it was possible that LS 71 had been abused at night, as there were two nurses on duty and they patrolled every fifteen minutes. He saw this incident as the most serious abuse which had occurred during the eighteen years that the unit was open at Lissue, but considered that it was bound to happen from time to time.[367]

249 Other instances of peer abuse were recorded in the Stinson Report. Nonetheless we would concur with Dr McAuley. In view of the disturbed behaviour of the children, some abuse is unsurprising. The reported episodes of peer abuse are not sufficient to conclude that the culture of the ward was sexualised. When abuse was reported, it was taken seriously and properly investigated, as LS 71's case indicated, and we do not consider, therefore, that peer abuse indicated any systemic failure.

Investigations since the Closure of Lissue Hospital

Introduction

250 As described below, further allegations of abuse were made in 1993, after the closure of Lissue but within the period covered by our Terms

365 LIS 051.
366 LIS 492, 552, 554.
367 Day 201, pp.92 to 93.

of Reference. Additional allegations were made in 2009, which led to a number of inquiries, reports, reviews and statements, covering different aspects of the services provided by Lissue Hospital and by its successor, Forster Green Hospital, which we did not investigate. Although these reports were prepared well after the end of our Terms of Reference, our conclusions will be judged in the light of their findings, and we have therefore taken their contents and conclusions into consideration.

Allegations: 1993 to 2008

251 In 1990 a female complainant, LS 67, said she had been sexually abused by a male member of staff at Lissue by being touched in the vaginal area, but despite repeated prompting she was unwilling to speak to the police, her family did not accept that the incident had happened and the matter was dropped.[368]

252 In May 1993 LS 66 who was not an applicant to the Inquiry, made allegations to Dr Hilary Harrison (then Hilary Reid) saying that fourteen years earlier LS 21 on about three occasions had lain on top of her on the floor, kissed her and ejaculated. LS 66 also said that both LS 21 and LS 78 injected her in the hip to sedate her, and were unnecessarily violent to children, dragging them down the corridor by the hair. She thought that LS 21 sexually abused other girls, and provided police with circumstantial evidence.[369] [370] [371]

253 Dr Harrison informed the Chief Social Services Inspector, Dr Kevin McCoy, and the police were informed. LS 21 denied all these allegations,[372] but he was placed on precautionary suspension from May to August 1993 while police inquiries proceeded.[373] Green Park Healthcare Trust does not appear to have conducted its own disciplinary inquiry and when the police decided to take no action on the grounds of lack of corroborative evidence, LS 21 was re-instated.[374]

254 While there may have been no corroboration from witnesses or documentation, such that the police could not be sure that they would obtain a guilty verdict, LS 66's evidence was detailed and persuasive, and

368 LIS 103, 247, 252, 255, 257, 260, 261, 266, 267, 270-272, 311, 800.
369 LIS 103-104, 275-276, 278-281, 31575, 31588-89.
370 Day 199, pp.59 to 62.
371 Day 200, pp.9 to 10.
372 LIS 60526.
373 LIS 283-305.
374 LIS 799-800.

the prime responsibility of Green Park Healthcare Trust was to ensure the safety of its patients. It should therefore have taken disciplinary action, independently of any police enquiries, and if they felt that there was a suspicion that the allegations were true.

255 On 26 October 1993, HIA 172 made allegations against five members of staff[375] but no evidence was found to corroborate his statement and no further action was taken.[376] The Director of Public Prosecutions confirmed on 11 April 1994 that there would be no prosecutions.[377] Police said reasonable force had been used by LS 8.[378]

256 In 1994, LS 67 again told a member of staff at Sharonmore, a Barnardo's project, that she had been abused at Lissue, and the police and other relevant authorities were informed, but she did not want the matter pursued.[379] In January 1997 Dr Hilary Harrison was concerned that these three separate allegations were not being considered together as they might have formed a composite picture. It should be noted that although LS 66, LS 67 and LS 68 all complained at different times about being sexually abused, they all said that they had been abused at Lissue in 1986.[380]

257 In May 2008, LS 69, a 33-year-old woman who had been a patient at Lissue for two periods between 1987 and 1991, named two boys and six staff (including LS 7 and LS 21) who had abused her either at Lissue or Forster Green Hospital between 1987 and 1991. She said she had been physically, mentally and sexually abused, having been stripped naked, locked in her room for two weeks, called names and 'touched'. There was a strategy meeting on 3 April 2008 at which various lines of action were agreed, including personnel checks on two of the alleged abusers who were still in Belfast Trust's employment.[381]

258 An investigation was undertaken by Geraldine Sweeney, Child Protection Nurse Advisor, and Anne McLean, Assistant Principal Social Worker, concerning LS 69's allegations against LS 79, which may have related to Lissue or Forster Green as she attended both hospitals during the

375 LIS 31222-31226.
376 LIS 31213.
377 LIS 31205.
378 Day 199, p.64.
379 LIS 800.
380 LIS 798-800.
381 LIS 105-106, 108, 315-321, 329-332, 30048-30122.

period 1987 to 1991. They did not interview LS 69 and found no direct corroboration of her allegations, though they were concerned about the "number and pattern" of reports of similar problems. A number of recommendations were made concerning staff training.

259 There was concern about LS 79, as the allegations against him were considered credible.[382] Five other children made allegations against LS 79, who was offered alternative work, but he went on sick leave and then left the work. Since his registration as a nurse lapsed he could not be subject to disciplinary proceedings by his professional body.[383]

Civil Claims[384]

260 It was in 2011, while the inquiries were proceeding, that HIA 172 repeated his allegations, complaining that "abuse was a daily occurrence", having contacted the Minister, Edwin Poots MLA.[385] Four former patients commenced civil claims during the following two years:

(1) On 25 September 2011, LS 115 alleged physical and sexual abuse between 1984 and 1986.[386]

(2) On 24 November 2011, HIA 220 complained of "negligence, assault, battery and trespass to the person" between 1975 and 1976.[387]

(3) On 27 January 2012, LS 116 alleged abuse by staff at Lissue.[388]

(4) On 4 July 2013, LS 17 alleged that around 1975 he was restrained in a jacket and helmet, physically restrained in a chair for hours without food or a toilet break, and frequently slapped and thrown against walls.[389]

Muckamore Abbey Hospital Review

261 In 2005 a former patient at Muckamore Abbey Hospital alleged that he had been sexually abused some 30 years earlier. Despite the scrutiny of the files of 300 Muckamore patients, there were no prosecutions arising from the inquiry which followed. The Department of Health and Social Services

382 LIS 119.
383 LIS 119, 13694-13707.
384 LIS 45001-45049.
385 LIS 107.
386 LIS 45005-45017.
387 LIS 45018-45025.
388 LIS 45026.
389 LIS 45027-45049.

nonetheless decided to use the Muckamore Abbey Hospital Review as a model to undertake a sampling exercise concerning all mental health and learning disability hospitals in Northern Ireland (other than Muckamore) with a special emphasis on minors and children, to identify any evidence of historical abuse. This major inquiry, which included Lissue Hospital, was established in 2007 and was being conducted by all five Trusts in parallel with the inquiries concerning Lissue described below.[390]

262 It was agreed that 10% of all files of patients during 1985 to 2005 would be sampled. However, the five Trusts interpreted their remits in different ways, with different sampling methods, and the resulting inconsistencies made it difficult to obtain a reliable overview of the situation across the province.[391] The review resulted in eight separate reports.[392] Eight categories of sexualised behaviour, physical abuse and other issues were drawn up. In the outcome, a large proportion of the sexual abuse recorded was between patients, and appropriate action had been taken wherever staff had abused patients.[393]

The RQIA Overview Report[394]

263 Although this report did not investigate Lissue, it was interlinked with the other inquiries listed here. The Regulation and Quality Improvement Authority review commenced in September/October 2007 and the report was completed in June 2008. It examined *Safeguards in Place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals* and noted the failure to implement child protection procedures and the variations in practice in the Trusts.[395] A number of recommendations were made with a view to establishing consistent good practice.[396]

The Stinson Report[397]

264 Following a strategy meeting on 8 July 2008, the Eastern Health and Social Services Board agreed a range of actions, including a review of Lissue files. A project group was set up, involving senior members of the

390 LIS 355.
391 LIS 451-452.
392 LIS 395.
393 LIS 355-367.
394 LIS 10576-10717.
395 LIS 379.
396 LIS 380.
397 LIS 10973-11027.

EHSSB, with a steering group which included staff from the Belfast Trust, the South Eastern Trust and the police. Bob Stinson, who was formerly a social worker and probation officer, was appointed as an independent consultant to undertake the review.[398] The purpose of the review was to identify any safeguarding issues in the records, such as references to sexual or physical abuse or grooming. The Stinson Report therefore commenced almost twenty years after the closure of Lissue Hospital.

265 A sample of 34 files was selected for the project, consisting of the records of all known complainants and other children mentioned in the complaints, together with twenty names selected at random by computer. Gaynor Creighton, a librarian, then produced summaries of these files and Bob Stinson reviewed the summaries.[399] The report consisted of a general discussion of key issues and recommendations, followed by summaries of the 34 cases.

266 None of the 34 people whose cases he considered have come forward to the Inquiry, but they included 23 who alleged or encountered abuse, including seven girls and one boy who alleged sexual abuse by peers and four boys and two girls who were the alleged abusers. There were three allegations that girls had been sexually abused by staff. There were also allegations of bullying and spontaneous adolescent brawls, grooming, restraint, sanctions, victimisation and humiliation.

267 Bob Stinson expressed concern at the frequency of the alleged abuse and the lack of follow-up action, suggesting failures of leadership, accountability and governance. He made a number of recommendations and presented his draft report on 5 March 2009, though the Department of Health, Social Services and Public Safety did not receive a copy until a year later.[400] It is not clear whether a final version was produced, as the versions which we have are all labelled as drafts, with differing titles, such as *Lissue Historical Cases Review Phase 2*[401] *or Independent Report Lissue & Forster Green Hospitals Historic Case Review*.[402]

268 As Lissue Hospital had been closed, the findings of the Stinson Report were not challenged by the authorities.[403] Since Bob Stinson was neither a nurse nor a doctor, it was argued that further investigations were required

398 LIS 109.
399 LIS 109.
400 LIS 109, 372, 378.
401 LIS 12327.
402 LIS 10973.
403 Day 200, p.21.

by professionals with the relevant training and experience to be able to make appropriate judgements. This led to the Devlin and Jacobs Reports.

269 Dr McAuley, who had not seen the Stinson Report prior to his preparation to give oral evidence to ourselves, took strong exception to two of the conclusions. He felt that the description of care at Lissue as "harsh and punitive" was "inappropriately strong" and he noted that the criticism of multidisciplinary co-operation was unfair as there were meetings of all the professionals every day of the week and most people got on well together.[404] He wrote that the frictions which existed were "largely caused by the different line management responsibilities of different disciplines", and felt the unit was "reasonably cohesive".[405]

The Burke and Sweeney Report[406]

270 In 2009, as part of Belfast Trust's post-Muckamore investigations, they appointed Margaret Burke, Principal Practitioner (Social Work) and Geraldine Sweeney, Child Protection Nurse Adviser, to undertake a *Retrospective Child Protection and Safeguarding Audit* which covered a ten-year period from January 1970 to December 1979, which was outwith the remit of the Stinson Report.[407]

271 Ten Lissue files from that period were reviewed and all types of record were considered. Seven of the cases reviewed indicated physical abuse by parents and there was some sexual activity on the part of two of the patients.[408] In most cases there was no record of any action having been taken, for example in relation to child protection, and the quality of record-keeping was considered "very poor throughout".[409]

The Devlin Report[410]

272 Maura Devlin, Director of Nursing and Midwifery Education, was then asked to consider the nursing at Lissue, and she produced a report entitled Review of the *Standard of Nursing Care provided to Children and Adolescents as Part of the Lissue Hospital Historic Review Case*. She reviewed a sample of only four files, and was critical of the standards

404 Day 201, p.148.
405 LIS 483.
406 LIS 10738-10762.
407 LIS 111, 367-370.
408 LIS 368.
409 LIS 369.
410 LIS 11082-11092.

of nursing reported in the records, seeing it as punitive in response to misbehaviour. She commented on the practice of LS 79, but said that her findings of poor professional practice were "suggestive rather than substantive".[411] She made a number of recommendations and presented her report in May 2009.[412] Although it was unclear whether action had been taken concerning all the allegations against nurses identified in the *Stinson Report*, Maura Devlin did not expand the scope of her study to obtain a broader picture of the prevalence of abuse.[413]

The Black Response[414]

273 D.I. Reuben Black wrote to Marion Reynolds on 9 May 2009, summarising the police view of the Stinson Report. There were two victims of abuse whom they had not traced, but all other reports of offences which were not statute barred had been investigated, and no action was planned.

The Reynolds Summary[415]

274 In July 2009 Marion Reynolds prepared a summary of the reports prepared to date, entitled *Interim Report in respect of Historic Review of Children Admitted to Lissue and Forster Green Hospitals Associated with [Serious Adverse Incident Report] SAI 117-08*, which was submitted to the Department of Health and Social Services with the Historic Case Review.[416] The report included a reference to the Devlin Report but was essentially a précis of the highlights of the Stinson Report.

The Jacobs Report[417]

275 Dr Brian Jacobs, Consultant Child and Adolescent Psychiatrist at the South London and Maudsley Foundation Trust, was then called in to consider the quality of medical and psychiatric treatment provided at Lissue. He wrote *Commentary Report on: Independent Report Lissue and Forster Green Hospitals Historic Case Review [sic]*.

411 LIS 11091.
412 LIS 110, 371, 374-375.
413 LIS 373.
414 LIS 11967-11970.
415 LIS 343-351.
416 LIS 110, 375-376.
417 LIS 11110-11123.

276 The report was based solely on the Stinson Report and consisted largely of comments and questions arising from Dr Jacobs's reading of the notes. He was not in a position, therefore, to gather evidence to form an independent view of the quality of psychiatric treatment at Lissue and Forster Green. He concluded that some children should not have been admitted as their problems were not psychiatric but reflected the inability of social services to manage them. He thought that Lissue and Forster Green were working within "a failing system", but the service provided by the medical staff was "clinically good". The report was criticised for failing to provide substantiation for these conclusions. Dr Jacobs reported in February 2010.[418]

The McMaster / Bamford / Devine Report[419]

277 In May 2010 Ian McMaster, Charles Bamford and Maurice Devine put together a critical analysis and summary of all the reports which had been prepared up to that time. Despite the weaknesses of the random sampling used in some of the inquiries, they felt that further investigations were unlikely to lead to any legal action.[420] They argued that any future investigations should be treated as child protection (or vulnerable adult) issues.[421]

Operation Danzin

278 All the information concerning possible offences identified in the inquiries was passed to the police, who were conducting an investigation under the title 'Operation Danzin'.[422] Although information was still being sought on some issues, no further police action was taken.[423]

Subsequent Action

279 The Stinson report was leaked to the *Irish News* in October 2011, and the media carried stories from people who were former patients at Lissue Hospital and its successor, Forster Green Hospital.[424] There were accounts of an anorexic boy being confined to bed when he did not eat,

418 LIS 371, 377, 12211.
419 LIS 355-384.
420 LIS 382.
421 LIS 384.
422 LIS 395.
423 LIS 396.
424 LIS 11541-11557.

children being beaten stripped, dragged by their hair, lifted up and thrown against a wall and confined to their rooms. The police said they were investigating and the Minister, Edwin Poots MLA, made a statement to the Northern Ireland Assembly.[425] On 28 November 2011 the Health and Social Care Board said that the allegations would be fully investigated by an independent inquiry into historical abuse being established by the Northern Ireland Executive.[426]

280 A further complication at this time was that the four regional Health and Social Services Boards were being wound up, and replaced by the single Health and Social Care Board. Dealing with the outcome of the various inquiries was therefore seen as a 'legacy issue' for the new Board.

The Strategic Management Group Final Report[427]

281 After a series of discussions, a Strategic Management Group (SMG) was set up by the Department of Health, Social Services and Public Safety because of concern about the inconsistencies in the previous inquiries, and it aimed to ensure that all necessary action had been taken in reporting matters to the police and referring disciplinary matters to regulatory bodies. It included representation of the DHSSPS, the Health and Social Care Board and the police, to determine how to proceed with the information produced by all of the inquiries.

282 Fourteen former patients of Lissue had contacted the police, and a further twelve cases had been reported. Several issues of concern were identified, but although 35 incidents were referred to the police, there were no prosecutions as a result of the retrospective sampling.[428] The ten cases concerning Lissue did not present any new concerns, though allegations already made by former patients were under investigation by the police.[429] Although some instances of abuse were identified which should have been reported to the police earlier, these were all referred to the police in the course of the inquiries.

283 The SMG concluded that, with one exception, appropriate action had been taken, that any criminal concerns had been reported to the police and that

425 LIS 11541-11548.
426 LIS 11549.
427 LIS 391-461.
428 LIS 803-806.
429 LIS 409.

any regulatory action required had been dealt with by employers.[430] This report was dated December 2013. By this time Forster Green Hospital was also closed[431] and the establishment of the Historical Institutional Abuse Inquiry had been announced.[432]

The McAndrew Overview[433]

284 Soon after she was appointed, Fionnuala McAndrew provided an overview of all the reports to the newly created Health and Social Care Board in 2014. This was seen as a "legacy" issue from the previous Board, and she said that in tying up the loose ends, she had four objectives:

> "(a) to deal with concerns of a child protection nature;
>
> (b) to make sure that anything which may be a criminal offence was appropriately dealt with;
>
> (c) if there are any professional issues about staff who were still employed in the system, then appropriate action was taken;
>
> (d) to satisfy themselves that the current care of children in a similar facility was appropriate."[434] [435]

285 Earlier, on 9 March 2011, Fionnuala McAndrew had written of both Lissue and Forster Green Hospitals that:

> "…it is also clear that children accommodated within these hospitals were subjected to a harsh and punitive regime, and that staff were challenged by the complex needs of the children, a poor physical layout and at times inadequate staffing levels."[436]

In oral evidence she said that it was not her personal opinion that care had been harsh or that there was poor multidisciplinary co-operation generally, but that these comments related only to the treatment of the children in the samples.[437] There were concerns about other issues such as the management of risky behaviour.[438] Her report was accepted by the Board.

430 LIS 111.
431 LIS 112.
432 LIS 398.
433 LIS 13714-13720.
434 Day 203, pp.6 and 7.
435 LIS 1444-1445.
436 LIS 11922.
437 Day 203, pp.8, 17.
438 Day 203, p.12.

286 Fionnuala McAndrew saw the reports as a jigsaw, each providing some of the scene, but she did not see the need for a fuller inquiry to complete the whole picture. As the Historical Institutional Abuse Inquiry was being established, she felt that it was not for her to determine whether a further inquiry into Lissue was required.[439]

Commentary

287 Four main issues arose from this series of investigations. The first is that a relatively small sample of files had thrown up quite a large number of cases where the records indicated that abuse either by peers or staff had been alleged. While only ten applicants have come forward to the Inquiry, the statements by some witnesses that other patients were also being abused clearly had some substantiation. Some of the allegations were known to the police, and none of the new information led to prosecutions. The absence of prosecutions should not be taken to imply that the allegations were without substance; among the reasons for deciding not to proceed was the fact that some of the alleged abusers had died.

288 The second issue is that the Stinson Report had concluded that the multidisciplinary co-operation at Lissue was poor. A number of people bridled at this conclusion. Dr Hilary Harrison, for example, provided oral evidence of good multidisciplinary cooperation at Lissue in relation to two children for whom she was responsible. There was good communication with consultant psychiatrists, psychologists and social workers both while the children were at Lissue and on discharge.[440]

289 As a social worker, LS 80 also gave evidence of interdisciplinary co-operation, such as the representation of all the professions (including the teachers) on the ward rounds, the siting of his office beside the ward, where he could observe behaviour and liaise readily with nurses, the participation of people from different professions in the video sessions (both as participants and observers) and the open access of records, so that the various professionals could read each others' observations.[441]

290 We agree that the evidence suggests that multidisciplinary working relations were good, particularly in the unhelpful context of the multiple accountabilities of the different professions to different employers and the

439 Day 203, pp.22 to 23.
440 Day 200, pp.20 to 21 and 30 to 31.
441 Day 200, pp.52 to 55, 62, and 68 to 69.

absence of any person with overall control of the Hospital, either internally or externally.

291 The third issue was the allegation that there was a "harsh and punitive" regime at Lissue. Dr Nelson denied that the regime was harsh or punitive.[442] LS 21 said that he did not consider it harsh, but there were rules, boundaries and limits to children's behaviour, and that breaching them had to be addressed as they could not tolerate a threat to the milieu and the stability of the regime.[443] Clearly, individuals cannot be treated properly in a chaotic setting, but equally this statement suggests that maintaining control of the unit could take priority over individual treatment plans.

292 Mary Hinds commented that the regime at Lissue was harsh from the patients' viewpoint, but not from the staff's; people who did not understand the philosophy of behaviour modification might see it as harsh. She felt that the reports failed to put their findings in a wider context.[444] Fionnuala McAndrew resiled from supporting Bob Stinson's conclusion, having cited it at an earlier date, saying that it applied only to the children considered in the sample, though she accepted that a wider review might have achieved "further understanding" of some of the actions.[445] The HSCB concluded that:

> "the available evidence in Module 13 does not support a view that the practices in Lissue as a whole were harsh and punitive. The HSB [sic] believes that such a view would ignore vital contextual factors about medical treatment and care."[446]

293 Dr Hilary Harrison said that on the basis of the evidence the Department accepted that, taking account of the standards at the time, the practice at Lissue appeared to be "very harsh and punitive".[447] When being questioned following allegations of abuse, LS 79 said that the regime was "tough" and that "there were a number of powerful individuals who persisted with the established custom and practice".[448]

294 We conclude that the evidence indicates that some of the treatment was harsh and that on occasion some of the nurses were rough with the

442 Day 201, p.148.
443 Day 199, p.79.
444 Day 200, p.115.
445 Day 203, p.25.
446 LIS 80058.
447 Day 200, p.35.
448 LS 13702.

children. This observation does not apply to all the staff, but there was sufficient rough handling of children for it to have been a predominant memory for some of the witnesses.[449] One of the problems may have been that behaviour therapy entails being firm with poor behaviour, and if this approach is adopted as a general mode of childcare in a unit rather than as a form of treatment for individuals with specific problems, it may provide a rationale for those who wish to treat children firmly, and it may then be only a short step to acting harshly.

295 Fourthly, there is the question of whether the combined reports, together with this Inquiry, have provided a sufficiently full picture of the services offered by Lissue Hospital. Mary Hinds pointed out that the authors of the reports did what was asked of them, but they did not provide the complete picture.[450] Fionnuala McAndrew saw the picture as a jigsaw, with each report adding more information.

296 The reports all showed weaknesses: the size of the Stinson sample was small, and Bob Stinson used material which had been pre-digested by a librarian. The Devlin and Jacobs reports essentially relied on Stinson, rather than considering the original evidence independently. Instances of historical abuse and poor practice were identified, but as the period in question related to two decades earlier, the value in studying it was primarily to check whether appropriate action had been taken, rather than to inform current practice.

297 As the number of files sampled was small, no doubt a fuller inquiry could turn up additional examples of abuse. However, it is doubtful whether additional examples would change the overall picture significantly. Former patients have now had the opportunity to complain to the bodies responsible for the services, to make civil claims, to speak confidentially to the Acknowledgement Forum and to give evidence publicly to the Inquiry. The fact that only ten witnesses have come forward to the Inquiry suggests that there are unlikely to be many more people who still wish to make allegations. **Any further inquiry into Lissue would be subject to diminishing returns; the additional information which might be gained could well be very limited and it would not justify the time and expense entailed**.

449 LIS 13716.
450 Day 200, pp.114 to 115.

Conclusion

298 For about forty years, from 1948 to 1989, Lissue Hospital was virtually the placement of last resort in Northern Ireland for children up to the age of thirteen, having to deal with a very wide variety of physical, medical, psychological and psychiatric problems, all on one site. With improvements in medical care, the nature of the problems changed considerably during those four decades, with a greater emphasis on paediatric care in the earlier decades and the creation of the psychiatric unit in 1971 to cope with the growing demand for help with psychiatric and behavioural problems.

299 Out of possibly 10,000 children who passed through Lissue Hospital only ten have come forward to the Inquiry to make allegations, eight of whom were patients in the psychiatric unit. Although by far the majority of the patients were in paediatric care, only two witnesses came forward who had been in this group. We conclude that the paediatric care at Lissue was not subject to systemic abuse.

300 The psychiatric unit was expected to cope with children with a wide variety of problems, ranging from physiological disorders such as encopresis or anorexia to those with behaviour or conduct disorders. Some of the children in the latter group could have been managed within the social services if special units had been available. Dr Jacobs criticised Lissue for the breadth of its intake, saying that the unit was working within a "failing system that was not of their making".[451] Dr Hilary Harrison commented that there were no alternatives in Northern Ireland for children with these problems prior to the development of a strategy for residential childcare in the 1990s.[452] According to Dr Nelson the social services in Northern Ireland did not have the resources to cope with the children presenting the most serious problems, unlike the London area, where he had also worked.[453] He argued that those who planned the system bore some of the responsibility for Lissue's problems. We agree.

301 This problem stretched beyond Lissue Hospital and its remit. It should be noted that when Dr Nelson decided that no child over thirteen should be admitted to Lissue as a day or residential patient, there was no alternative residential psychiatric provision for adolescents aged over thirteen in

451 LIS 11121.
452 Day 200, pp.33 to 34.
453 Day 201, p.144.

Northern Ireland. They had to be placed in adult wards or admitted to residential childcare placements such as training schools. HIA 172, for example, having spent time at Lissue and Rathgael, had to be placed in an adult psychiatric ward at Downshire Hospital at the age of thirteen. It was realised that nowhere in Northern Ireland could provide the unconditional caring he required.[454]

302 The response to this broad psychiatric remit was the creation of a consultant-led multidisciplinary team which applied a variety of innovative treatment methods, including psychotherapy, family therapy, behaviour modification and the use of drugs.

303 The treatment plans for individual children were a medical matter, and we have made no comment on them other than to report some of the evidence provided by witnesses. A few of the allegations were clearly based on misunderstandings about legitimate treatment methods, and we have discounted them. By way of example, as Dr Nelson noted, staff dealing with violent children or insisting on feeding by tube might have looked rough or forceful, but it was a necessary part of some children's treatment plans.[455]

304 Of the various treatment systems, the behaviour modification advocated by Dr McAuley became the dominant mode adopted by the nursing staff and it was applied generally to all patients. When the psychiatric unit was set up, this model was innovative, but it has now been widely adopted. It is a good model, particularly for changing specific aspects of a child's behaviour by setting clear boundaries and insisting on them, to discourage unacceptable behaviours and to ensure that the parent or caring adult is in control, providing security for the child.

305 The HSCB considered that:

> "the nature of the behavioural treatment programmes and the exercise of professional judgment about when to begin and end techniques such as time out occasions may have led to inconsistency in practice and, on occasions, may have gone beyond what was appropriate."[456]

They did not, however, "accept that this extended to systematic abuse of children".[457]

454 LIS 1383-1384.
455 Day 201, p.135.
456 LIS 80041.
457 LIS 80038.

306 It is our opinion that the abuse of which the witnesses have complained may have arisen when the approach was misapplied, not as part of the planned treatment for individuals, but as a means of managing and controlling the children as a group. In this respect there were times when the punitive aspects of the model appear to have been applied by some staff too harshly, for example in prolonged periods of time out, in the rough physical handling of children when isolating them, in the use of strapping to confine children to their beds, in the use of pyjamas throughout the day, or in the use of medication for control purposes. Moreover, the evidence of witnesses suggests that children were not always given the affection they needed to experience, whether as a reward for good behaviour or as part of their normal upbringing. The witnesses have acknowledged that they presented severe handling problems, for example by climbing on the roof, but we consider their allegations as persuasive that some of the ways in which they were treated by some staff were systemically abusive.

307 HIA 426 provided an account of sexual abuse in the earlier years of Lissue. During the later years, evidence of sexual abuse related largely to two individuals, LS 21 and LS 79, and in both cases there were multiple witnesses, either to this Inquiry or in earlier investigations, who alleged abuse by these nurses. These allegations do not suggest that the sexual abuse of patients by staff was extensive, but it was a misuse of power and breached their duty of care to vulnerable children; the evidence indicates systemic abuse. There was evidence of peer sexual abuse, but it was insufficient to conclude that there was a sexualised culture and when it was reported to staff appropriate action was taken.

308 Lissue Hospital worked within the wider health service in Northern Ireland. While the level of resourcing appears to have been adequate, there were serious defects in the governance and management structures. From 1973 onwards there was no one person responsible for Lissue Hospital either in the internal structure or externally up to Board level. Yet the professionals were expected to work together as a multidisciplinary team; we have already noted that it is to their credit that they worked together as effectively as they did. Furthermore there was no system of inspection, and the visits made by external agencies and individuals amounted to no more than a patchwork of observations. If there had been a system of regular inspections, some of the problems reported by the witnesses might have been avoided.

309 In summary, while acknowledging the allegations of harsh and inappropriate treatment and sexual abuse, for four decades Lissue Hospital played an invaluable role providing a wide range of services to children with paediatric, psychiatric and behavioural problems.

Summary of Findings

310 **It is our view that the governance structure from 1973 onwards was a systemic failure, and it is fortunate that it did not engender serious management problems.**

311 **The successes of the psychiatric unit at Lissue were thanks to cooperation between the individual professionals involved; the managerial structure within which they worked was faulty and systemically unsound.**

312 **In the circumstances we consider the absence of both formal and informal inspections of Lissue Hospital on a regular basis to have been a systemic failure on the part of the Ministry of Health and Local Government and the Northern Ireland Hospital Authority from 1948 to 1973, and on the part of the Ministry / Department of Health and Social Services and the Eastern Health and Social Services Board from 1973 to 1989.**

313 **While we cannot say what the outcome of a disciplinary inquiry might have been, we consider the failure of the Green Park Trust to conduct its own investigations into the allegations of sexual abuse against LS 21 in 1993 to have been a systemic failure which left children at risk of abuse.**

314 **In view of the risk to the children who climbed on the roof at Lissue and the danger which they caused to other people, the lack of action to prevent access to the roof was a systemic failure.**

315 **The occasions on which physical restraints were used may have been few, but their use was unacceptable; they would not have been used in other types of residential childcare, and their use in a hospital cannot be justified.**

316 **While the policy was not at fault, the implementation of time out at times was not always in accordance with the policy and constituted systemic abuse.**

317 **On the occasions when children were sedated to render the nursing task easier, the use of injections constituted systemic abuse.**

318 **It is our opinion that at times some staff did overstep the mark and were unduly rough in their treatment of the children, and that this constituted systemic abuse.**

319 **We accept that some patients were sexually abused and consider this to have been systemic abuse.**

320 **It is our conclusion, however, that there were many instances when staff were unfeeling and failed the children who required their support, and that these shortcomings were sufficiently frequent to be deemed systemic emotional abuse.**

Chapter 25:

Module 15 – Kincora Boys' Home

Introduction

1 Module 15 of the Inquiry's public hearings was devoted to an examination of Bawnmore Boys' Home and Kincora Boys' Home. As nineteen of the twenty sitting days from Tuesday 31 May 2016[1] until Friday 8 July 2016[2] were devoted to our investigations into Kincora, we deal with Bawnmore in a separate chapter of our Report. Because of the complexity and gravity of the allegations relating to Kincora, we depart from our practice elsewhere in this Report of dealing with a particular institution in a single chapter, and we devote several chapters to examining the history of Kincora and the allegations relating to it.

2 In the second chapter we examine the experiences of the residents in the home throughout Kincora's existence. In the third chapter we examine the investigations by the Belfast Welfare Authority and by the Eastern Health and Social Services Board (EHSSB), which took over responsibility for Kincora in 1973, into allegations of sexual abuse of residents in Kincora which came to their attention. Because some of these allegations came to the attention of the Royal Ulster Constabulary (RUC) we also examine in that chapter the way in which the RUC dealt with the allegations that came to its attention. As the response of the Belfast Welfare Authority, and later the EHSSB and the RUC were inter-connected in various ways it is convenient to consider all of these matters in a single chapter. In this chapter we set out the background to the matters we consider in greater detail in chapters two and three.

3 In the fourth chapter we consider whether the security services in the form of the RUC Special Branch, the Secret Intelligence Service (sometimes referred to as MI6), the Security Service (also referred to as MI5), and British Army Intelligence knew of sexual abuse of residents in Kincora, and whether any of these agencies exploited, connived in, or ignored the sexual abuse of residents of Kincora. In that chapter we also consider the response of various Government departments over the years to the allegations relating to Kincora. This will involve an examination of not just the security services described above, but the Northern Ireland Office, the Ministry of Defence and the Cabinet Office as well. In the fifth chapter we draw together our conclusions regarding all aspects of the events relating to Kincora that we have examined.

1 Day 204.
2 Day 223.

Background

4 In May 1958 the Belfast Welfare Authority, or more precisely Belfast Corporation Welfare Committee, as the statutory authority for the provision of social services in general, and for the provision of childcare in particular in Belfast, opened a hostel for working boys who had left school on completion of their secondary education. At that time the school leaving age was fourteen. Although commonly referred to as Kincora Boys' Home in later years, this was a hostel for working boys and when we refer to Kincora throughout these chapters it must be understood that we are referring to a hostel for working boys.

5 The hostel occupied a substantial Victorian dwelling house located at 236 Upper Newtownards Road in east Belfast. Then, as now, the Upper Newtownards Road is one of the main thoroughfares in east Belfast and the building was located on the corner of the junction of the Upper Newtownards Road and North Road. The hostel, which was closed in October 1980, was intended to be for working boys between the ages of fifteen and eighteen who were in care. There were occasions when boys up to 21 might be accommodated,[3] and it is known that on occasions younger boys were admitted.[4] The building consisted of two floors and an attic when it opened, and it originally accommodated eleven residents, but this number was reduced to nine when the attic was no longer used. Between May 1958 when it opened and October 1980 when it closed, 370 boys resided in Kincora. Altogether there were 580 admissions to the hostel,[5] but as many were readmitted on a number of occasions the number of those who lived there was 309.[6] As we shall see, in later years a one-storey extension was added to the rear of the building which provided an office and a separate bedroom for the use of the warden of the hostel, Joseph Mains. We should point out that the building is no longer in public ownership, and has been privately owned for a considerable number of years.

6 Kincora continued to be run by the Belfast Welfare Authority until the welfare authority was absorbed into the newly created EHSSB in 1973 when local government in Northern Ireland was reorganised. From 1973 it was run by the EHSSB. Throughout its existence from 1958 until 1980

3 KIN 1085.
4 KIN 1086.
5 KIN 1086.
6 Day 204, p.39.

the warden and officer in charge was Joseph Mains. For a considerable period Mains was the only member of staff responsible for the care of the boys in the home, although he had the assistance of a cook and a cleaner to deal with domestic matters. From September 1964 until February 1966 Raymond Semple was employed as an assistant warden. Semple left in 1966, but returned in June 1969 and continued to work in Kincora as the assistant warden until he was suspended in March 1980. The number of staff was further increased to three with the appointment of William McGrath as house father in June 1971. McGrath worked in that capacity in Kincora until he was also suspended in March 1980. Mains and Semple were suspended at the same time.

Allegations in the *Irish Independent*

7 On 24 January 1980, the Irish Independent newspaper published an article[7] making a number of grave allegations of sexual abuse of boys in Kincora, and these matters where taken up by Gerry Fitt MP in the House of Commons. Mains, Semple and McGrath were all suspended by the EHSSB pending the outcome of a major investigation that was immediately started by the RUC.

8 There were several allegations in the *Irish Independent*.

(1) Boys at the home had been recruited for homosexual prostitution.

(2) A police report had been sent to the Director of Public Prosecutions (DPP) but no action was taken.

(3) Reports on certain cases were destroyed under orders from a senior member of the "Social Services Department".

(4) A member of staff at the home who was alleged to be involved with a small loyalist para-military group was suspected of encouraging children to engage in homosexual acts for money, and still held a senior position at the home.

(5) The police report named a number of important Northern Ireland businessmen as being involved in the abuse of children in the home.

(6) One of the children involved was alleged to have committed suicide, and a second to have attempted suicide.

(7) The matter first came to light in 1977.

7 KIN 11529.

(8) One boy who knew of the child prostitution was not provided with support by social workers when he faced a criminal charge, because it was thought advisable to have him locked up where he could not talk.

(9) Police files on the allegations currently existed in RUC stations at Strandtown and Donegall Pass.

(10) Some offences were alleged to have involved boys as young as twelve.

The first police investigation

9 A major police investigation was immediately set in train led by Detective Chief Inspector Caskey. During its existence this investigation expanded to include other children's homes, including Bawnmore Boys' Home (which is dealt with in Chapter 22 of our Report), and Williamson House, both in north Belfast. We shall refer to this investigation as Caskey Phase One, which resulted in a 121-page report from DCI Caskey, together with over 200 witness statements deemed relevant to the criminal investigation, as well as over a further 100 witness statements not directly relevant to the criminal investigation. The entire file, including DCI Caskey's 121-page covering report, amounted to 1,709 pages.[8]

The prosecutions

10 During the police investigations Mains and Semple admitted various homosexual offences, some of which were committed with individuals who were no longer resident in Kincora when those offences occurred. McGrath denied all the allegations put to him. The DPP directed that a total of 33 charges be brought against them, and Mains, Semple and McGrath were sent for trial on 1 September 1981. Each of them pleaded not guilty to the individual charges against them on 27 November 1981, and their trial started on 10 December 1981 before Lord Lowry, Lord Chief Justice of Northern Ireland. Mains and Semple then changed their pleas to guilty on various charges. Semple admitted each of the four charges against him.[9] Mains admitted six of the eleven charges against him, and the prosecution accepted those pleas and entered a *nolle prosequi* on the five remaining

8 KIN 10001-1170
9 KIN 101001

charges, thereby effectively withdrawing them.[10] McGrath maintained his pleas of not guilty to all of the charges against him, and the first witnesses were called on the afternoon of 10 December.[11] On the next day McGrath changed his pleas to guilty on fifteen of the eighteen charges against him, and the prosecution entered a *nolle prosequi* against him on the three remaining charges.

11 The decision of the prosecution not to proceed with a number of the charges against Mains and McGrath reflected their assessment of the difficulty of establishing those particular charges to the criminal standard of proof beyond reasonable doubt, and the decision to effectively withdraw the charges by entering a *nolle prosequi* was a normal and perfectly proper course for them to adopt.

12 On 16 December 1981 Lord Lowry sentenced the accused as follows.

(1) Mains received six years imprisonment on two charges of buggery, two years imprisonment on one charge of indecent assault and three charges of gross indecency. All the sentences were concurrent, making a total of six years imprisonment in his case.[12]

(2) Semple received five years imprisonment on each of two charges of buggery, and two years imprisonment on each of two charges of gross indecency. All the sentences were concurrent, making a total of five years imprisonment in his case.[13]

(3) McGrath received four years imprisonment on each of two charges of buggery, and two years imprisonment on each effecting charges of either gross indecency or indecent assault. All the sentences were concurrent, making a total of four years imprisonment in his case.[14]

We refer to the sentencing of these accused in greater detail in the next chapter.

10 KIN 101002.
11 KIN 101016.
12 KIN 21258.
13 KIN 21259.
14 KIN 21260-KIN21261.

Bone, Elder and Witchell

13 Mains, Semple and McGrath were not the only men convicted of the homosexual abuse of children in their care as a result of the Caskey Phase One investigation. Peter Bone pleaded guilty to sixteen charges of the 22 charges against him, and was sentenced on 16 December 1981 to a total of two years imprisonment on eight charges of gross indecency and eight charges of indecent assault. All the sentences were concurrent.[15] Some of the offences were committed whilst he was assisting in a voluntary capacity at Bawnmore Boys' Home.[16]

14 Robert Dewar Elder also pleaded guilty on 16 December 1981 to one charge of indecent assault and one of gross indecency, and was sentenced to a total of one year's imprisonment, suspended for two years on each count. These offences also involved a boy at Bawnmore.[17]

15 On 16 December 1981 Eric Witchell pleaded guilty to six charges of indecent assault and gross indecency. The prosecution entered a *nolle prosequi* on a charge of buggery.[18] These charges related to offences committed by Witchell against three boys who were residents at Williamson House,[19] a children's home also run by the EHSSB. He was sentenced to 18 months imprisonment on each count, the sentences to run concurrently.[20] Bone, Elder and Witchell were sentenced by Lord Lowry on the same day as he sentenced Mains, Semple and McGrath. That six males were sentenced on the same day for sexual offences committed by them at three homes run by the Belfast Welfare Authority and its successor the EHSSB is a sign of the extent of the investigation carried out by DCI Caskey and his officers in the Caskey Phase One investigation. That investigation was not confined purely to Kincora, or indeed Bawnmore or Williamson House, because it expanded to include allegations relating to several other institutions, including the De La Salle School at Rubane. We consider the Rubane allegations elsewhere in this report.

15 BWN 20665.
16 BWN 20665.
17 BWN 20026.
18 KIN 40221.
19 KIN 40220.
20 KIN 40221.

Further investigations

16 When passing sentence on Mains, Semple and McGrath, Lord Lowry expressed his surprise that their crimes had gone undetected for so many years. On 17 December 1981 the EHSSB decided to set up a committee to enquire into the home.[21] In the following weeks there were further allegations about what had happened in Kincora, notably in three articles by the journalists Ed Moloney and Andrew Pollak published in the Irish Times on 12, 13 and 14 January 1982.

17 We will consider these allegations in the next chapter, but for present purposes it is sufficient to note that in the article of 12 January 1982 it was alleged that;

> "The northern authorities blocked an RUC investigation into an alleged homosexual prostitution ring in 1976 which involved British officials in the Northern Ireland Office, police men, legal figures and business men and boys in care at the Kincora Boys Home and other homes run by the Eastern Health Board…".

The article also alleged that the ring was believed to have been in existence for at least three years, and it was suspected that the ring involved at least seven men, two of whom were British civil servants on secondment to the Northern Ireland Office.[22]

18 On 13 January the article dealt in some detail with allegations that between 1975 and 1977 concerns about homosexual offences involving boys in care in Kincora were passed on to their superiors in the EHSSB by at least four social workers, but they were told not to pursue their enquiries in case they prejudiced an ongoing police investigation at the time. This article also referred at some length to the experiences of two former residents at Kincora, one of whom it was said jumped from the Liverpool boat into the Irish Sea whilst being sent back to Belfast from Liverpool and was drowned. Misgivings about the case of the other, who it is clear was Richard Kerr, combined with what was alleged to be "apparent inaction on the part of the authorities concerning other allegations finally persuaded a number of social workers to publicise the Kincora affair".[23]

21 KIN 21311.
22 KIN 21312.
23 KIN 21316.

19 In the third and final article on 14 January 1982 the allegation was made that the Belfast Welfare Authority was alerted about homosexual offences in the Kincora Boys Home in 1971 but failed to take any action. The article described the experiences of an ex-resident who wished to remain anonymous and who lived in Kincora between 1968 and 1971. The ex-resident, who gave evidence in due course to the Hughes Inquiry when he was known as R 8, sent two letters dealing with his experiences to the Belfast Social Services but never received a reply.[24]

20 These allegations, and other similar allegations that appeared in other newspapers, such as an article in the *Irish Independent* on 13 January 1982 by Peter McKenna, whose article of 24 January 1980 in the *Irish Independent* sparked the Caskey Phase One investigation, and calls by a number of Northern Ireland MPs for an investigation into these matters, no doubt contributed to the announcement on 15 January 1982 by the then Secretary of State for Northern Ireland, the Rt Hon James Prior MP that he had set up a Committee of Inquiry into Children's Homes and Young Persons Hostels. The Chairman of the Committee was Stephen McGonagle, previously the Northern Ireland Parliamentary Commissioner for Administration and Commissioner for Complaints, or the Ombudsman as the holder of the combined posts was more usually described.[25] There were four other members, two of whom were leading figures in the social work field from England, and the other two were individuals of some standing in Northern Ireland. One of these was Dr George Humphreys, the Chairman of the Northern Health and Social Services Board. He resigned shortly afterwards because he had a relative connected with the social services in the Eastern Board, which was to be the main focus of the Inquiry.[26] Dr Humphreys was replaced by a distinguished former headmaster, Dr Stanley Worrall.[27]

21 It is unnecessary to set out the Terms of Reference of the McGonagle Committee because it proved to be very short-lived. It came to an end on 12 February 1982 after only two witnesses had been called, Mr Fitt MP and Detective Superintendent Caskey, who by now had been promoted from Detective Chief Inspector.[28] Three members of the committee said that they felt unable to continue until all police enquiries had been completed.

24 KIN 40983.
25 KIN 21270.
26 KIN 21273.
27 KIN 21272.
28 KIN 20004.

22 The reference to police enquiries was to a decision by Sir John Hermon, the Chief Constable of the RUC, on 10 February 1982 to set up a further investigation. This was also led by Detective Superintendent Caskey under the direction of Assistant Chief Constable (ACC) John Whiteside.[29] On 18 February 1985 Sir John Hermon announced that in order to allay public concern into what he described as "much rumour and unsubstantiated information", he had appointed the same team of RUC detectives (i.e. Detective Superintendent Caskey and his officers) to establish if there was any substance to the rumours and unsubstantiated information.[30]

23 Other allegations had been made on the BBC television *Scene Around Six* programme by the journalist Christopher Moore on 11 February 1982,[31] based on an allegation by another ex-resident of Kincora, Hugh Quinn. On the next day, Friday 12 February, Hugh Quinn also appeared on a BBC *Spotlight* programme on Kincora. The programme referred to:

> "...Rumours about prostitution rackets, security forces interest in one of the accused and allegations and counter allegations about who knew what, and when and how."[32]

The programme also raised specific issues as to why complaints in 1967 and 1971 did not result in police prosecutions, and why later complaints were not followed through.[33]

Sir George Terry's investigation

24 Sir John Hermon also announced that because of inferences which had been made about the way in which the police had conducted their enquiries, "In order to put the matter beyond any doubt and to alleviate public concerns", he had requested the appointment of an outside chief constable to investigate these allegations. He stated that the outside chief constable:

> "Will have full access to all the papers past and present and in addition will have general oversight of the continuing investigations. In due course he will forward a report to me and his conclusions will be made public".[34]

29 KIN 20005.
30 KIN 21277.
31 KIN 20920.
32 KIN 20926.
33 KIN 20927.
34 KIN 21277.

Sir George Terry, the Chief Constable of Sussex Constabulary, agreed to take on this task. He was assisted by two officers from his force, Superintendent Harrison and Superintendent Flenley.[35]

25 The appointment of Sir George Terry and his officers from the Sussex Constabulary meant that two parallel investigations took place. As we shall see, the Sussex officers reviewed the entirety of the Caskey Phase One investigation, and re-interviewed many of those interviewed by the RUC in the Caskey Phase One investigation. They explicitly raised with the Kincora ex-residents whether they had been aware of homosexual activity involving people from outside the home. Superintendents Harrison and Flenley produced extremely detailed and comprehensive reports, and although their reports were part of, and relied upon by Sir George Terry in his report, they have not hitherto been published. Sir George Terry described his published report as "a summary together with relevant background, of the enquiries", carried out by himself. As he emphasised, his report should be read in conjunction with the separate report prepared by Superintendents Harrison and Flenley.[36]

26 Sir George Terry's report was delivered on 27 May 1983 and later published. To distinguish it from the longer report by Superintendents Harrison and Flenley, we shall refer to their investigations and reports as being the Sussex Police Report to distinguish them from the distinct report by their Chief Constable, which we refer to as the Terry Report.

Caskey Phase Two investigation

27 On 26 August 1982 Detective Superintendent Caskey submitted his 211-page report on his Phase Two investigation which was part of a file which, including witness statements and other documents, amounted to 1,702 pages. During that investigation his enquiries extended to British Military Intelligence, and included allegations in respect of John Colin Wallace, a former member of the Army Information Service stationed at British Army Headquarters Northern Ireland (HQNI) at Thiepval Barracks in Lisburn, Co Antrim. In view of the sensitive nature of those enquiries, and the attachment to the report of documents which were classified, 'secret' or 'confidential', it was agreed between the Director of Public Prosecutions in Northern Ireland (the DPP) and the ACC Crime of the

35 KIN 40001.
36 KIN 40001.

RUC that this file would be submitted to the DPP under "Secret Cover". We refer to this separate and secret file as Caskey Phase Three. That file was submitted by Detective Superintendent Caskey on 16 March 1983 and consisted of a 58-page covering report, 106 pages of witness statements as well as exhibits and other documents amounting to 407 pages in all.[37] The DPP later issued a direction that there be no prosecutions on the Caskey Phase Two file. On 16 May 1983 the DPP issued a further direction that the initiation of criminal proceedings against any persons was not warranted on the information and evidence contained in the Caskey Phase Three file, and the file was therefore marked "No prosecution".[38]

The Hughes Inquiry

28 Following the termination of the work of the McGonagle Committee of Inquiry, on 18 February 1982, the Secretary of State for Northern Ireland announced in the House of Commons that he did not propose to reconstitute that Inquiry. He recognised the need:

> "To investigate the failure to identify earlier malpractices in some [homes and hostels for children and young persons] and to examine and assess present policies, procedures and practices for their administration".

He continued:

> "In these circumstances, after the current police investigations and any consequent criminal proceedings are complete, I intend to appoint a committee, with a High Court Judge as Chairman, sitting in public. The Terms of Reference of such an Inquiry and the powers it might need cannot be determined until the results of the present investigations are known. But I am anxious that there should be no lasting cause for public disquiet that the truth has not been wholly discovered."[39]

29 In exchanges which followed his statement, the Secretary of State responded to questions by Mr Gerry Fitt MP as to whether the proposed inquiry would have power to take out of prison those who had been convicted because of allegations at Kincora. This was presumably a

37 KIN 30001–30407.
38 KIN 100020.
39 KIN 21274.

reference to Mains, Semple and McGrath. Mr Fitt also asked whether the Inquiry:

> "Would enable Mr Colin Wallace, a former British Army security spokesman, who gave an interview to journalists in 1975 and made them aware of all the aspects of Kincora, to be brought before the Inquiry or the courts?"

30 The Secretary of State replied to these points by saying:

> "The hon gentlemen asked about the powers of the Tribunals of Inquiry (Evidence) Act [1921]. He asked whether, if we decided on that type of Inquiry, the Inquiry would have power to call for people who had been imprisoned for one offence or another. Such an Inquiry has complete powers to call for evidence from whomsoever it desires. Therefore, the answer to his question is 'Yes'."[40]

31 In the event, the Secretary of State did not appoint a Committee of Inquiry under a High Court judge, nor was the Inquiry set up under the 1921 Act. With the publication of the Terry Report and the earlier decisions of the DPP to direct no prosecution in relation to the matters considered in the Caskey Phase Two and Phase Three reports, on 18 January 1984 a Committee of Inquiry was set up with his Honour William Hughes, a recently retired circuit judge in England, as Chairman. As well as Judge Hughes (to use the title by which he was commonly referred to thereafter), the other members were Mr W J Patterson and Mr H Whalley. The Committee (which we shall refer to as the Hughes Inquiry) was appointed on 21 March 1984 by the Department of Health and Social Services for Northern Ireland (the DHSS) by virtue of the powers conferred on it by Article 54 and Schedule 8 of the Health and Personal Social Services (Northern Ireland) Order 1972.[41] In a later chapter we shall examine the reasons why this course was adopted instead of the original promise that a tribunal of Inquiry under the 1921 Act chaired by a High Court judge would be appointed once the police enquiries and any subsequent prosecutions had been concluded.

32 The Hughes Inquiry conducted 60 days of public hearings, during which a number of ex-residents of Kincora, and a substantial number of other witnesses from Belfast Welfare Authority, the EHSSB, the DHSS and the RUC gave evidence. We shall consider parts of the evidence given

40 KIN 21275.
41 KIN 75380.

during the oral hearings, and of the 340-page report that relate to Kincora in greater detail in later chapters. It is sufficient to note at this stage that the findings and recommendations of the Hughes Inquiry helped to contribute to major changes in childcare practice in Northern Ireland, particularly in the fields of recruitment, training and the terms and conditions of staff.

33 The investigations carried out by the Hughes Inquiry were not confined simply to the Kincora Boys' Home, because they investigated eight other children's homes or hostels.

- Valetta Park Hostel, Newtownards, Co. Down.
- Bawnmore Hostel, (which we examine elsewhere in this report).
- Williamson House Children's Home.
- The Palmerston Reception Assessment Centre.
- The Nazareth Lodge Children's Home in Belfast.
- The De La Salle Boys Home at Rubane House, Kircubbin, Co Down.
- Barnardo's Sharonmore Project.
- Manor House outside Lisburn, Co Antrim.

In our Inquiry we have examined all of these homes, and refer to them elsewhere in our Report, with the exception of Valetta Park Hostel, Palmerston Reception and Assessment Centre and Williamson House.

34 In relation to Kincora, the Hughes Inquiry expressly considered whether there had been a "cover-up" in respect of two periods. It defined a "cover up" at 3.174 as:

> "The failure of persons in positions of responsibility to take action appropriate to their office and/or the destruction or suppression of information or records, in pursuance of an improper motive."[42]

35 The first period concerned complaints by residents and ex-residents up to 1971. The Hughes Inquiry pointed out that:

> "No person ever came forward with evidence of a deliberate or concerted 'cover-up' of the Kincora scandal by the Belfast Welfare Authority, but publicity frequently suggested that one may have been organised."[43]

42 KIN 75251.
43 KIN 75251.

At 3.175 the Inquiry expressly rejected the suggestion that either Mr Mason, the senior official in the Belfast Welfare Authority at the time, or Mr Moore, his deputy, had been engaged in a cover-up of allegations against Mains, which were investigated in 1967. At 3.176 the Inquiry took the view that Mr Mason's recommendation to the Town Clerk that the 1971 complaints against Mains should be referred to the police clearly absolved him from any "cover-up" allegation, and concluded that they could not find that there was a "cover-up".[44]

36 At 3.177 they said:

> "We received no complaints that the Belfast Welfare Committee became aware of complaints or suspicions concerning the Kincora staff, except through Mr Moore's comment to the late Councillor [Joss] Cardwell. There is no evidence that Councillor Cardwell took steps to prevent or suppress the matter. Nor is there any evidence that the Ministry of Home Affairs became aware of allegations or rumours relating to homosexual misconduct at Kincora".[45]

The reference to the Ministry of Home Affairs was because that ministry was the department responsible for the regulation and inspection of children's homes in Northern Ireland during the first period.

37 In their conclusions regarding Kincora, the Hughes Inquiry dealt with allegations that there had been a 'cover-up' in years subsequent to 1971 at paragraphs 4.226 to 4.230. They concluded that there were only two aspects of the way various officers of the EHSSB dealt with allegations, or suspicions, about Kincora that, "required serious consideration in the context of a possible "cover-up"". They rejected that either of those aspects could be so considered and stated at 4.228, "...the evidence against a concerted "cover-up" is overwhelming".[46]

38 In the published Summary of his Report Sir George Terry expressed a number of conclusions that are relevant to Kincora.

- There was absolutely no evidence that residents of any children's home were involved in anything resembling homosexual rings of the type alleged.[47]

44 KIN 75251.
45 KIN 75251.
46 KIN 75300.
47 KIN 40019.

- While there was a lack of awareness over intelligence, and some information which was not as thoroughly recognised, there was no "cover-up" or concealment of evidence, or disciplinary breaches by the RUC personnel.[48]
- No complaint was received by the RUC from any victim at Kincora, or other boys' homes, until the Caskey Phase One investigation was launched in 1980.
- In the absence of such complaints there were limits to the action which could be taken by the police on the basis of unsubstantiated rumours or allegations.
- That said, there were several occasions which should have attracted greater interest and a more positive approach.
- These occasions were due to inadequacy or inefficiency, and were lapses in professionalism.
- Despite these lapses, he did not consider that an earlier investigation would reasonably have been prompted on the basis of information available to those officers.[49]
- Despite his attempts to persuade reporters to provide him with evidence or the identity of witnesses who could substantiate their allegations of a "homosexual ring", no reporter provided any fresh or real evidence, and he considered that, despite the evidence the reporters claimed was available, they had no such evidence.[50] He concluded that there was no justification in the allegations that there was an involvement in any homosexual practices [in or relating to Kincora] by British officials in the Northern Ireland Office, or any action by them to suppress police enquiries in that connection.

39 He made the following observation about the allegation that some in military circles were aware of homosexual activity in Kincora.

> "The media have also given a degree of prominence to the fact that some Military circles were aware of homosexual mis-practice in the Kincora Boy's hostel. The military sources had been very frank with me and perfectly open during the ongoing enquiry by our own team under Detective Superintendent Caskey. Let me say quite clearly

48 KIN 40020.
49 KIN 40020.
50 KIN 40021.

> that once more I sought evidence from all sources including the military with negative result".[51]

We shall consider these particular comments further in the chapter dealing with the security services.

40 We have already mentioned the remarks of Mr Fitt MP in the House of Commons on 18 February 1982, when he referred to Mr Colin Wallace having allegedly given an interview to journalists in 1975 during which, in Mr Fitt's words [Mr Wallace] "made them aware of all the aspects of Kincora". In a later part of this Report, we shall examine the allegations made by Mr Wallace over the years. At this stage it is sufficient to say that it was not until 1984 that a document emanated from him which he claims was drawn up by him in November 1974. This document is of great significance in the sequence of events relating to Kincora, as was recognised by the RUC at the time. They passed the document to the Hughes Inquiry. As we shall see in due course, the Hughes Inquiry was unable to persuade Mr Wallace to answer a number of pertinent questions relating to this document, nor were the police, despite considerable efforts by both to persuade Mr Wallace to cooperate with them. Because of doubts about the authenticity of the November 1974 document, Detective Superintendent Caskey carried out a further investigation relating to that document. His file containing his report, and the associated statements and exhibits, was submitted to the ACC Crime on 28 August 1985. We shall call that Caskey Phase Four.

41 In the succeeding chapters of this Report, when we consider the relevant material relating to the role of social services and other departments and agencies in the events concerning Kincora, we shall examine in greater detail material from: the four Caskey files; the Sussex Police investigations; the transcripts of evidence given to the Hughes Inquiry; those parts of the Hughes Inquiry Report which directly concern Kincora; as well as material from other sources.

42 For the purposes of this introductory chapter it is enough to say that despite the emphatic conclusions expressed by Sir George Terry and by the Hughes Inquiry - that each of them had found no evidence to support the allegations of a cover-up of the abuse of residents at Kincora, or of a homosexual vice ring involving residents at Kincora and prominent public figures, civil servants at the Northern Ireland Office and others -

51 KIN 40023–40024.

allegations to that effect persisted. Allegations have also persisted that the RUC and the security services were aware of the abuse of boys in Kincora, and either failed to prevent that abuse or exploited it in various ways.

43 These allegations have been made by many individuals over many years in various ways in newspaper articles and in television programmes. They have also been made, examined or referred to in a number of books, notably in *Who Framed Colin Wallace* by Paul Foot, first published in 1989; in *The Dirty War* by Martin Dillon published in 1990; and in *The Kincora Scandal political cover up and intrigue in Northern Ireland* by Chris Moore, first published in 1996.

44 Colin Wallace was dismissed from his position as a civilian employee of the Army Information Services of the Ministry of Defence in 1975 in circumstances which we shall examine in due course. In 1980 he was prosecuted for the murder of Jonathan Lewis, with whose wife he had been having what was described by the Court of Appeal in 1996 as an "amorous but not adulterous affair". On 20 March 1981 he was acquitted of the murder of Jonathan Lewis, but convicted of his manslaughter and sentenced to ten years in prison. Colin Wallace's first appeal against his conviction was dismissed in February 1982; he served his sentence and was released in 1986. His conviction was later referred to the Court of Appeal by the Home Secretary, and on 9 October 1996 the Court of Appeal Criminal Division allowed the appeal and quashed his conviction for manslaughter.

45 In 1989 certain materials discovered by the Ministry of Defence (MOD) led it to look again at the circumstances of Colin Wallace's dismissal in 1975. David Calcutt QC was appointed to review the material relating to the dismissal. He concluded that Colin Wallace's dismissal had not been justified and recommended that he be paid £30,000 compensation. The MoD accepted the recommendation. As will be apparent in a later chapter, the circumstances surrounding Colin Wallace's dismissal from his post in 1975, and what he alleged then and subsequently, are inextricably bound up with any examination of what he says did or did not happen in Kincora, and what the security services, including Army Intelligence, did or did not know about the sexual abuse of boys in Kincora. The relevance of Colin Wallace's conviction, and ultimate acquittal, on the charge of manslaughter of Jonathan Lewis to this Inquiry, is that when he was in prison between 1980 and 1986 he engaged in a voluminous

correspondence with a great many public figures, including the Prime Minister, in an attempt to establish his innocence on the charge that resulted in his conviction. During that time, in his correspondence, Colin Wallace made numerous allegations about Kincora as part of his argument that he was dismissed from his civilian employment in 1975 because of what he said he knew about Kincora, and his belief that his knowledge was instrumental in his being wrongly prosecuted and convicted of the manslaughter of Jonathan Lewis. He also made a number of allegations about what he maintained was malpractice on the part of the security services in relation to various activities in Northern Ireland.

46 For many years the British Government rejected all allegations of any involvement of the security services in the abuse of boys at Kincora, relying upon the findings of the Hughes Inquiry and of Sir George Terry, as well as the absence of any charges being brought as the result of the extremely detailed investigations carried out by the police in the form of the Caskey Phase Two, Phase Three and Phase Four investigations, and the investigations by the Sussex Police.

47 Following the commencement of this Inquiry, a number of applicants to our Inquiry said that they were abused whilst they were resident in Kincora, and on 4 September 2013 when we announced the first thirteen institutions that we intended to investigate, Kincora was included. The constitutional division of responsibilities between the Government at Westminster and the Northern Ireland Executive gives the Northern Ireland Executive responsibility for, and the Northern Ireland Assembly the legislative competence to deal with, only those functions that had been devolved to Northern Ireland. This meant that our investigation into Kincora would necessarily be restricted to considering those organisations such as the Belfast Welfare Authority, the EHSSB, and the police, which were at some time in the past the responsibility of the Northern Ireland Government of the time.

48 Our statutory powers are contained in the Inquiry into Historical Institutional Abuse Act (Northern Ireland) 2013, (the 2013 Act), which is an Act of the Northern Ireland Assembly passed to enable our Inquiry to investigate institutional abuse in Northern Ireland in those homes within our Terms of Reference between 1922 and 1995, as set out in a statement to the Assembly made by the First Minister and deputy First Minister acting jointly on 18 October 2012. Section 9(2) and 9(3) of

the 2013 Act embodied that restriction by limiting our powers to require individuals to give evidence and to produce documents or any other thing to the Inquiry. The announcement in 2014 by the then Home Secretary, the Rt Hon Theresa May, that she intended to set up an independent Inquiry into child abuse in England and Wales resulted in calls within Northern Ireland that matters relating to Kincora should be examined by that Inquiry. In response to questions posed by the then First Minister, the Rt Hon Peter Robinson MLA on 17 July 2014 the Chairman replied to the effect that whilst the Inquiry was already committed to investigating whether there were systemic failings in relation to Kincora, unless Westminster departments such as the MoD and the Home Office,

> "Voluntarily agreed to co-operate they cannot be compelled to produce documents, nor can we compel anyone from those departments, serving or past to assist the HIA Inquiry in the way we can when dealing with institutions or official bodies in Northern Ireland".

49 However, the situation changed when, in the Autumn of 2014, the Northern Ireland Office approached the Inquiry to ascertain what our view would be were Her Majesty's Government to enhance the work of the Inquiry to enable all the allegations relating to Kincora to be properly investigated by this Inquiry, a matter that was being considered by the Home Secretary and the Secretary of State for Northern Ireland. As the result of a meeting between the Chairman, the Inquiry Secretary and Inquiry Solicitor with the Permanent Under Secretary of the Northern Ireland Office and his officials on 16 October 2014 the Chairman set out out four requirements that would have to be met by Her Majesty's Government before the Chairman could accept the suggested enhancement of the role of this Inquiry.

(a) Details of all files relating to Kincora held by all UK Government Departments and agencies would be provided to this Inquiry.

(b) A senior civil servant will confirm to the Inquiry at a suitable time that all relevant files have been produced or accounted for.

(c) That the additional cost that the Inquiry would incur in investigating the non-devolved UK Government Departments and agencies that the Inquiry may have to investigate would be covered in principle by HM Government.

(d) That a suitable form of immunity would be provided by the Attorney General for England and Wales for witnesses who co-operate with the Inquiry and in particular that undertaking would relate to any allegation of an offence arising under the Official Secrets Acts.

50 On 21 October 2014 the Home Secretary and the Secretary of State for Northern Ireland announced to the House of Commons that they felt that as this Inquiry was already in being and intended to investigate Kincora, and that as the protection of children was a devolved matter, it was felt that this Inquiry was the better forum to investigate all aspects of what happened at Kincora. The Secretary of State then gave a number of assurances which met the Chairman's four requirements. In particular she said:

> "There will be the fullest possible degree of co-operation by all of HM Government and its agencies to determine the facts";

and

> "All government departments and agencies who receive a request for information or documents from the Inquiry will co-operate to the best of their ability in determining what material they hold that might be relevant to it on matters for which they have responsibility in accordance with the Terms of Reference of the Inquiry".

51 The Inquiry welcomed these assurances, saying that:

> "As we have already announced, and as the Secretary of State has said, the HIA Inquiry is investigating Kincora, and so her announcement does not extend the Terms of Reference of our Inquiry. On the contrary, it now provides our Inquiry with the means to investigate the activities of non-devolved Government Departments and agencies.
>
> We are satisfied that the assurances of full co-operation by all Government Departments and agencies, and the satisfactory resolution by HM Government of the other issues the Inquiry has raised with it, will provide our HIA Inquiry with the ability and financial resources to carry out an effective and thorough investigation into all the Kincora allegations.
>
> However, should it become apparent during our work that it is necessary to have powers under the Inquiries Act 2005 then we will ask OFMDFM and HM Government to confer such powers on our Inquiry".

52 Following the assurances given by the Secretary of State for Northern Ireland to the House of Commons, the Inquiry immediately put in train the steps we considered necessary to expand the scope of our investigations to enable it to investigate the actions of the non-devolved departments

and agencies relating to Kincora, particularly the MoD regarding Army Intelligence, the Security Service (MI5), the Secret Intelligence Service (MI6), the Northern Ireland Office and the Cabinet Office. As part of the process, we requested the Police Service of Northern Ireland to make available to us a large quantity of material relating to the various investigations carried out by the Royal Ulster Constabulary, including relevant files held by RUC Special Branch.

The Hoy judicial review

53 The decision by the Secretary of State to request the Inquiry to expand its investigation into Kincora was challenged in an application to the High Court for judicial review brought by Gary Hoy, a former resident of Kincora and applicant to the Inquiry. The judicial review was initiated in 2015 and brought against the Secretary of State for Northern Ireland and the Inquiry. In addition to affidavits sworn by Gary Hoy himself, supporting affidavits were filed by a number of individuals, including Richard Kerr to whom we refer in the next chapter. The judicial review application was based on a number of grounds which can be seen from the judgment of Mr Justice Treacy, and that of the Lord Chief Justice when delivering the judgment of the Court of Appeal.

54 From the Inquiry's perspective, the key issues were firstly whether the Inquiry's investigation into any involvement in the sexual abuse of residents at Kincora on the part of state agencies had to comply with the provisions of Article 3 of the European Convention on Human Rights. Secondly, if the Inquiry had to comply with Article 3, whether its powers and procedures were capable of complying with Article 3. The Inquiry's position was that irrespective of whether or not Article 3 applied, if the Inquiry felt that it was not receiving full assistance from British Government Departments and Agencies, it would not hesitate to say so and, if necessary, request the First Minister and deputy First Minister and the Secretary of State for Northern Ireland to confer on the Inquiry such powers under the Inquiries Act 2005 as might be necessary. The Inquiry also submitted that in any event the application was premature, and that the time to consider whether Article 3 applied, and if so whether it had been complied with, was after the Inquiry had conducted its investigations and delivered its Report.

55 On 8 April 2016 Mr Justice Treacy dismissed the application, describing it as "premature and misconceived". On 27 May 2016 the Court of Appeal dismissed the appeal, stating that the Inquiry was entitled to proceed along the path mapped out by it, and on 31 May 2016 the Inquiry started its public hearings into Kincora.

The Inquiry's investigation into Kincora

56 Following the assurances given by the Secretary of State to the Inquiry in October 2014 the Inquiry expanded its investigation into Kincora to include the non-devolved departments and agencies, and we shall explain our work in that area in greater detail in the appropriate chapter. At this stage we need only briefly outline the steps taken. The Inquiry asked for details of all files relevant to Kincora held by all the non-devolved departments of Government, as well as those held by the Secret Intelligence Service and by the Security Service, to be notified to the Inquiry. Once details of those files were given to the Inquiry the work of examining the files got underway as soon as other Inquiry commitments permitted. The examination of the files which seemed likely to contain the most important and relevant documents was given priority by the Inquiry, and started in April 2015. This work continued despite the judicial review so that the Inquiry would be in a position to start its public hearings at the conclusions of the judicial review proceedings if the courts upheld the Inquiry's position. Had the Inquiry not taken the precaution of proceeding with its investigative work during the judicial review, even at the risk of an unfavourable outcome for the Inquiry, it would have been impossible for us to have completed our public hearings by 18 July 2016 as we were required to do within the revised timetable given to us by the Northern Ireland Executive and Assembly when we were given an extra year to complete our work.

57 At the beginning of the hearings held by the Inquiry into Kincora on 31 May 2016 the Chairman explained that the Inquiry intended to investigate the following issues.

(a) The nature and extent of sexual abuse perpetrated on residents of Kincora; abuse that resulted in the arrest, conviction and sentence of Mains, Semple and McGrath.

(b) Who perpetrated that abuse.

(c) Whether the abuse of boys resident in Kincora occurred in Kincora itself or elsewhere in Northern Ireland.

(d) When such abuse occurred.

58 He explained that the Inquiry intended to investigate "whether there were systemic failures to prevent such abuse on the part of those responsible for the management of Kincora or on the part of other state entities". He explained that the following entities would be investigated.

(a) Belfast County Borough Welfare Committee and Department and its successor the Eastern Health and Social Services Board.

(b) The Royal Ulster Constabulary.

(c) The Secret Intelligence Service.

(d) The Security Service.

(e) The Ministry of Defence.

(f) The Northern Ireland Office.

59 He then explained that in relation to each of these entities the Inquiry intended to investigate the following matters.

(a) Whether members of the organisation or body concerned knew of the abuse.

(b) What they knew.

(c) When they knew.

(d) What did they do with any knowledge they had.

(e) What should they have done with any knowledge they had.

He explained that the Inquiry intended to consider:

> "The full ambit of previous investigations carried out into Kincora arising from, or connected with, these matters, as well as the responses of these organisations or bodies to those investigations. This will include the Hughes Inquiry, several investigations by the RUC, and the investigation carried out by the Sussex Constabulary under the direction of Sir George Terry. It will also involve the examination of the steps taken in later years by the RUC, the Secret Intelligence Service, the Security Service, the Ministry of Defence, the Northern Ireland Office and the Cabinet Office to address the allegations made in the media and elsewhere about what the various state agencies did, or did not know, about the sexual abuse of children in Kincora, and what those agencies did, or should have done with any such knowledge."

60 Having pointed out that the Inquiry did not need to resort to powers of compulsion "when there is voluntary and full co-operation, by those from whom information and documents are sought", the Chairman confirmed that the Inquiry had been provided with full and voluntary co-operation by all HM Government departments and agencies. He also confirmed that we were satisfied that we had been able to inspect all relevant material held by the PSNI, as the successor to the RUC, which the Inquiry considered relevant to its work.

61 We want to repeat what was stated by Junior Counsel to the Inquiry on several occasions during the nineteen sitting days devoted to an examination of events relating to Kincora, namely that we have been able to examine in unredacted form all documents which we have had produced to us. Although there is a very substantial quantity of hitherto secret material (including the four voluminous Caskey files to which we have already referred) held by the SIS, by the Security Services, by the RUC Special Branch, by the NIO and by the Cabinet Office, these documents, or extracts from them, are part of an even greater quantity of material held by these various agencies and departments which the Inquiry has examined as part of its work. We have been given complete access to all the files we wished to see, and the Inquiry has studied all of the material contained in those files, and not just the material which it has publicly referred to. We did not consider that every page of every file, or every part of every page, needed to be produced or examined in public. Some of the material was not relevant to the issues we set ourselves to examine. Other parts that were relevant, such as the identity of serving or retired officers of the security services, or agents of any of these agencies, or others who were engaged in intelligence work, could not be published in case the safety of those individuals or the interests of national security were endangered. Whilst we took into account the views of the security services, and of Government departments, when deciding what should be published or what should be redacted (that is, blacked out in the text) we have been able to publish everything that we believed was necessary to be published.

62 From the beginning of our work on Kincora we have proceeded on the basis that as much as can be properly put before the public must be, and has been made, publicly available, thereby enabling everyone who wishes to know what happened in Kincora to see the documents which we had publicly examined. In the interest of maximum disclosure,

wherever reasonably possible, we did this in completely open sessions, so that our total commitment to carrying out a comprehensive and thorough investigation can be scrutinised. In doing so, and having decided for ourselves the extent and manner to which we should carry out our investigations, we have been conscious throughout that, in the words of the Lord Chief Justice in the judgment of the Court of Appeal in the Hoy case:

> "There is a suggestion in this case that children in Kincora were abused and prostituted in order to satisfy the interest of national security. If that is true it must be exposed. ...If the suggestion is not true the rumour and suspicion surrounding this should be allayed".

Chapter 26:

Module 15 – Kincora Boys' Home

PART FIVE

PART SIX

PART SEVEN

PART EIGHT

The Nature and Extent of the Sexual Abuse of Adolescent Boys Resident in Kincora

PART ONE

Introduction

1 In the first part of this chapter we examine the accounts given by ex-residents to the Caskey Phase One and Phase Two investigations, to the Sussex Police, and to the Hughes Inquiry. We also consider accounts given by some residents on other occasions, whether in the form of newspaper or television interviews, or as in the case of Gary Hoy and others, in affidavits made by them which were then lodged in the course of legal proceedings. Finally, we examine the accounts given by the former residents and others who gave evidence to this Inquiry. In addition to the accounts given by ex-residents, we also consider the accounts given by others who had relevant contact with Kincora, such as social workers and former officials of the Belfast Welfare Authority or the EHSSB. Almost all of this material was examined in considerable detail during the public hearings devoted to Kincora, and may be found in the daily transcripts of those hearings on our Inquiry's website, or in the documents referred to during the hearings; documents which we have also placed on our website. Whilst on occasion it will be necessary to set out relevant matters in some detail, in general we confine ourselves to summarising those parts of the evidence to be found in the transcripts and documents on our website that are relevant to the issues we consider.

2 As will become apparent, the sexual abuse of residents in Kincora varied in intensity and in the nature of the abuse at various stages of the almost 22 years existence of the hostel, and so we examine these stages over five distinct periods. The first of these relates to the six years and four months from the opening of the hostel in 1958 until September 1964 when Raymond Semple joined Joseph Mains as assistant warden.

3 As we explained in the previous chapter many boys were admitted to Kincora on more than one occasion, and allowing for this a total 309 boys resided in Kincora from its opening in 1958 until its closure in

1980. The Caskey Phase One investigation took 1963 as its starting point, and stated that 186 boys resided in Kincora between 1963 and 1980. However, an analysis of the admissions register by the PSNI for the purposes of this Inquiry concluded there were 245 boys in Kincora between 1963 and 1980. 104 boys from that period were traced and interviewed during Caskey Phase One, or 42% of former residents during that time.[1] As we shall see a number of others came forward at various times and made allegations about their experiences in Kincora.

Period One: May 1958 to September 1964

4 As we have explained, during this period of over six years warden Mains was the only care staff member in Kincora, apart from eight months in 1962, and eleven months from July 1963 until May 1964, when he was given the services of an assistant warden. Between May 1958 and the end of September 1964, 89 boys were admitted to Kincora although some of these were admitted on more than one occasion. Of the 89, four said that they were abused by Mains during this period, and we examine their accounts separately.

The Evidence of R 2

5 R 2 was not an applicant to our Inquiry, but did give evidence to the Hughes Inquiry which gave him the designation R 2, and we have given him the same designation. Although several boys had been admitted to Kincora before he arrived at the beginning of January 1959, R 2 was one of the earliest to be admitted, and he remained a resident for two years and two and a half months until he left in mid-March 1961. He was readmitted at his own request in mid-June 1961, and remained a resident in Kincora until he was discharged a second time in September 1961. He was therefore in Kincora for almost two and a half years. He was fifteen and eight months of age when he first arrived, and nineteen and a half when he left for the last time.

6 R 2 was only questioned by the RUC in 1980 because other ex-residents had told the police that he visited Kincora regularly after he left. R 2 was almost 38 when he was traced by the RUC. When he made his first statement, R 2 admitted that he had had sex with Mains every two or three months for almost twenty years until 1978. Sex would take place

1 KIN 1582.

in Mains's flat at Kincora, that is the extension added at the back of the building where Mains had a bedroom and an office. In his first statement to the RUC during the Caskey Phase One investigation in April 1980 R 2 said that this relationship only started after he left Kincora, and that nothing happened between them whilst he was a resident in Kincora. Mains had given a similar account to the RUC when he was questioned. When R 2 was medically examined on behalf of the police in 1980 he repeated to Dr Irwin that he had not been sexually abused at Kincora.[2]

7 When questioned a second time by the RUC in May 1980 Mains admitted engaging in masturbation with R 2 whilst R 2 was a resident in Kincora, and, as he had already admitted, anal intercourse with R 2 in Kincora, but after R 2 ceased to be a resident there. Consensual anal sex between adults was still a criminal offence in Northern Ireland at that time. At his trial in 1981 Mains only faced one charge of gross indecency in respect of the masturbation of R 2 whilst a resident in Kincora. He faced a second charge of buggery, which covered the entire period of their relationship up to 1979.[3] This was in accordance with the usual practice of only laying a single charge which covered a lengthy period of time, rather than have numerous charges covering a longer period and thereby complicating the task of the court and the jury, if a jury had to deal with a case.

8 Although the sex between Mains and R 2 usually took place in Mains's bedroom in Kincora during a period after R 2 stopped being a resident, R 2 said that on one occasion he had sex with Mains in the home of BAR 1 who was Mains's girlfriend, although she was not there at the time.

9 After Mains had been sentenced to a total of six years imprisonment at the end of 1981, R 2 subsequently gave a significantly different account. As explained in the previous chapter, by early 1982 there were numerous articles in newspapers making allegations about Kincora. On 19 February 1982 R 2 wrote a letter to Gerry Fitt MP asking a number of questions about Kincora, and he gave a copy of this letter to the police on 1 March 1982. On that date he made a further police statement, and on 30 March 1982 that was followed by another statement. In these statements R 2 described how Mains viewed him in the bath and then fondled and kissed him. This was followed by persistent

2 KIN 10715.
3 KIN 101069.

overtures by Mains that R 2 go to bed with him, to which R 2 eventually succumbed. Oral and anal intercourse then took place on approximately ten occasions in Mains's room upstairs in Kincora, spread over both periods when R 2 was resident in the hostel. R 2 said that he had kept up the relationship because he felt unable to cope, and as Mains was in "such a high and respected position I felt trapped". He explained he did not complain to the welfare officers who visited Kincora because they did not pay any heed to the children, and because "I felt that my complaints would not have been heeded or even looked into in any depth".[4] It is clear from this later account that R 2 was persuaded, that is seduced, by Mains when he took part in sexual activity with Mains in Kincora as a resident.

10 When questioned about these allegations, Mains maintained that the relationship did not start until after R 2 left Kincora. D/Supt Caskey recommended no further proceedings against Mains, pointing out that had this additional information been made known when Mains was sentenced it was unlikely to have resulted in a heavier sentence.[5] This is a common position taken by police, prosecutors and judges when further allegations of similar offences that have already been dealt with are later brought against an accused who has already been sentenced.

11 We shall return to R 2 later, but before leaving him at this stage there are four matters that deserve to be mentioned. The first is that R 2 maintained that Mains was the only man with whom he had sexual relations. Secondly, over the years of their relationship he visited Kincora and stayed overnight with Mains on occasions. Thirdly, the relationship lasted for many years after R 2 ceased to be a resident in Kincora. R 2 told the police in 1980 that he "didn't like any kind of sex but I didn't like to refuse because I treated Joe as a personal friend and not as a sexual partner".[6] Finally, R 2 served for a time in the RUC Reserve, and sometimes visited Mains at Kincora whilst wearing his police uniform.

4 KIN 21247.
5 KIN 20199.
6 KIN 10151.

The Evidence of R 3/HIA 199 (Hugh Quinn)

12 Whatever R 2 may have believed the nature of the relationship between Mains and himself to be, he was not the only boy sexually abused by Mains whilst R 2 was a Kincora resident because Mains was also abusing R 3 during the period. R 3 also gave evidence to the Hughes Inquiry and we have continued his designation although he gave evidence to our Inquiry under the designation HIA 199. For the sake of consistency we shall refer to him as R 3 in this Report as well. He spent at least three periods in Kincora between February 1960 and August 1963. After R 3 left Kincora he returned from time to time to see Mains, and stayed over on occasions.

13 R 3 was first admitted to Kincora in February 1960 when he was just over fourteen, and he remained there for sixteen months until he left in June 1961. Only two weeks later he was re-admitted, and remained in Kincora for a further thirteen months until he was discharged in July 1962 aged sixteen to attend the National Sea Training School at Gravesend in Kent. This did not work out and he was re-admitted in early August 1962. He remained a resident in Kincora until he was finally discharged a year later in August 1963, by which time he was seventeen and eight months of age. We note that the Hughes Inquiry believed that he was discharged aged eighteen and a half in May 1964. As we have already explained, R 3 was one of those boys who was well under fifteen when admitted, and who remained a resident in Kincora for a long time.

14 R 3 did not make any complaints about Mains until he was identified to the RUC by other ex-residents as someone who had regularly returned to Kincora. Mains was therefore questioned about R 3 before R 3 had been interviewed by the RUC. Mains initially only admitted masturbation with R 3 whilst R 3 was a resident, but in a second interview later that day admitted that he had anal sex with R 3 on several occasions in 1963 and 1964 while R 3 was living in Kincora. Mains admitted being the dominant partner in these acts of anal intercourse, saying that R 3 was the first person with whom he had anal sex.[7] R 3 gave evidence to our Inquiry under the designation HIA 199. He described how he was sometimes punched and slapped by Mains in his office or in the bedroom, and he believed that this was to remind him of the

7 KIN 10420.

consequences if he did not submit to Mains's sexual demands.[8] Mains accepted that he had made a remark to the effect that if R 3 did not pull himself together, "the next step for him would be Borstal". Whether intended as a threat or not, it was entirely understandable that R 3 interpreted the remark as a threat. At the trial Mains was charged with two offences against R 3, one of buggery for which he received six years imprisonment, and one of gross indecency to represent the masturbation for which he received two years in prison.

15 R 3 also gave evidence to the Hughes Inquiry. He returned to Kincora on several occasions after he left, as well as sending cards. He told the Hughes Inquiry that he returned every year until around 1969, but did not return again until 1979. His visits are corroborated by an entry in the Kincora registers that he stayed for two weeks between 22 December 1965 and 2 January 1966. R 3 was emphatic to us that the relationship between Mains and himself was not consensual, as Mains claimed to the police, but was one where R 3 felt that he was forced by a mixture of threats, such as the reference to Borstal, gifts and privileges, such as being taught to drive, and the fear of being disbelieved.[9] He explained that despite what Mains had done, R 3 felt that he was safe in returning to Kincora[10] because he regarded Mains as a father figure and as Kincora was the only home he still had, and because the abuse had stopped when he told Mains he would tell on him.

The Evidence of KIN 1

16 R 2 and R 3 overlapped at Kincora between February 1960 and September 1961 and so it is clear that Mains did not confine his sexual abuse to one boy at a time during that period. That pattern was repeated with KIN 1 who overlapped with R 3 between February and August 1963. KIN 1 came to Kincora at the beginning of May 1963, when he was fifteen and nine months, and remained there until he left aged seventeen and four months in early November 1964. His allegations against Mains were of less gravity than those of R 2 and R 3. They were confined to two episodes where he described Mains adopting a pretext to touch him around his private parts. The first was when KIN 1 told Mains he had a pain in his groin, whereupon Mains told him to

8 Day 209, pp.81 and 82.
9 Day 209, p.89.
10 Day 209, p.91.

drop his trousers and underpants and then felt around his private parts. Two or three months later he described how he was told to go and have a bath. Mains then came in, locked the bathroom door behind him and washed around the private parts of KIN 1 with his hands. KIN 1 told him he was old enough to do this himself and Mains left because someone called him.[11] KIN 1 made complaints relating to three occasions when he said R 3 made unmistakable sexual approaches to him whilst both boys were resident in Kincora. R 3 denied these allegations, as well as the allegation by KIN 1 that it was general talk amongst the boys that R 3 was interfering with other boys in the hostel, something he said he witnessed for himself in his bedroom when he was supposed to be asleep.

17 Although a charge of indecent assault was brought against Mains based on the allegations by KIN 1, Mains pleaded not guilty to that charge at his trial, and the prosecution did not proceed with the charge because Mains was pleading guilty to the other charges against him. Again that is a usual course for the prosecution to take in such circumstances.

The Experiences of R 7

18 The last boy to be admitted to Kincora during this first period and who was abused by Mains was R 7. He spent three periods in Kincora, arriving in August 1964 aged fifteen years and two months, and remaining until December 1965 when he was sixteen and a half. He was abused by Mains during this period. He was then discharged but was re-admitted in March 1966, and remained in Kincora for a further six and a half months until September 1966. During this time he was abused by Semple but not by Mains. R 7 was re-admitted in November 1968 for a third time. By now he was seventeen and five months of age and he remained in Kincora for a further two and a half months until he was discharged for the third and last time in January 1968 aged nineteen and a half. We should say there is some uncertainty about when he was discharged, with various accounts giving January or December 1968. However, this is not significant because R 7 has not alleged that he was abused during this third and final period in Kincora. Although the first period he spent in Kincora straddles the end of the first period that we are presently considering, we consider his accounts of his experiences

11 KIN 10160.

with Mains fall more conveniently into this first period, and we will return to his accounts of his experiences with Semple when we consider the next period.

19 R 7 said that shortly after he first arrived in Kincora, and so presumably in, or not long after, August 1964 when he was aged fifteen Mains made his first sexual approach to him. This was when he was getting out of the bath and Mains grabbed him around the testicles. About a week later he described how Mains invited him into his bedroom, and after feeling around his testicles, pulled down R 7's trousers and underpants. He then pushed him face down on the bed and attempted to anally penetrate him. R 7 pulled away, whereupon Mains said something to the effect that R 7 wasn't much good and let him leave the bedroom.

20 When questioned, Mains denied the attempted anal penetration, but admitted he had been involved in masturbation with R 7. At his trial Mains was charged with attempted buggery of R 7, to which he pleaded not guilty, but he admitted the offence of gross indecency with R 7 in respect of the masturbation. As Mains had pleaded guilty to other offences of buggery the prosecution did not proceed with the charge of attempted buggery of R 7.

21 It can be seen from these descriptions that Mains picked on some boys, usually making the first approach when the boy was bathing. Then he would make a further approach when he would attempt to persuade, or to force, the boy to submit to anal intercourse. If the boy agreed, or gave in, anal intercourse would take place and be repeated on other occasions. If the boy rejected his advances then Mains would turn elsewhere. It is significant that Mains would make his first sexual advance when he was alone with the boy, and that later offences were committed in secret in Mains's bedroom, which at that time was on the first floor of Kincora. As R 3 said to the Hughes Inquiry, "all sex activity in Kincora was secretive, otherwise we would have been discussing it with each other".[12] R 3 also explained to the Hughes Inquiry that Mains told him to go to his bedroom after dark when the lights were out and the other boys were asleep, and in the morning to wait until the cook had gone into the kitchen before returning to his own bed.[13]

12 KIN 71316.
13 KIN 71333.

22 A similar account of the way Mains carried out his crimes was given by R 2. He wrote that his bed was in the bedroom adjacent to Mains's bedroom on the first floor. He described how Mains's:

> "method to get me sneaked into his room was, by the way he was checking around the rooms and would close each door on his way out where he would stand on the landing beckoning me to cross over into his room saying all was clear".[14]

23 Given the secrecy in which these offences were committed, it is not surprising that Mains was successful in concealing from others what was happening. Another factor in his concealment of his crimes was because he only approached some boys and not others. This is illustrated by the evidence of KIN 3 in his statements to the RUC in 1980, and to the Sussex police in 1982. KIN 3 was in Kincora from April 1963, when he was fifteen and two months of age, until the end of July 1964 when he left aged sixteen and a half. During the sixteen months he spent in Kincora he said:

> "I didn't know of anything going on. I was out nearly all the time and only slept there. I was never approached in a sexual way".[15]

As we have already explained, apart from two periods totalling approximately nineteen months when there was an assistant warden, for the rest of the time we are presently considering, Mains was the sole member of the care staff, and as such the only person in the building apart from the cook, and she was unaware of what was happening. That Mains was alone in the building for long periods of time, and many of the boys were either out or otherwise engaged, meant that he had ample opportunity which he made use of in order to commit offences on boys in his care without either being discovered or arousing suspicion.

PART TWO

Period two: 8 September 1964 to 28 February 1966

24 During this eighteen-month period 50 boys were resident in Kincora, including KIN 1, R 3 and R 7. Leaving KIN 1 and R 3 out of account because their experiences of abuse were confined to period one, which we have already considered, that leaves 48 other residents during period

14 KIN 21250.
15 KIN 11585.

two. Of those 48, twelve were traced and interviewed by the police, either as part of the Caskey Phase One investigation or subsequently, as in the case of KIN 127, who approached the police himself in 1982. Of the twelve who have been traced at some stage it has been established that six boys were sexually abused by Mains, and of these six, two (R 1 and R 7) were also abused by Semple. This period of eighteen months has been chosen because it covers the first period of Semple's two periods of employment as assistant warden at Kincora. We consider the accounts of the boys who were abused first, and then we consider the accounts of the other six residents who were traced but did not allege that they had been sexually abused during this period.

The Experiences of R 7

25 As we have already described, R 7 was abused by Mains during period one. Semple first joined the care staff as assistant warden in September 1964. R 7 was one of those residents who were admitted to Kincora on more than one occasion, and his first period in the hostel came to an end just before Christmas 1965. He returned for a second time two and a half months later at the beginning of March 1966. He alleged that during his second period in Kincora, that is from March 1966 onwards, he was sexually molested by Semple who came into the bathroom, dried his bottom and then made R 7 face him and pulled R 7 towards him. R 7 gave evidence to the Hughes Inquiry and said that Semple left him alone when he rejected his advances. He said he thought that Semple's actions were more about getting a cheap thrill, and although he did not regard Semple's advances as very serious, he did not want them to continue. Significantly, he described Semple as a very kind hearted person who was liked by the boys, most of whom got on very well with him.[16]

26 As R 7 did not return to Kincora until after Semple left in February 1966, R 7 may have been mistaken when he attributed Semple's actions to the period when R 7 was in Kincora for the second time. That is because Semple did not return, at least on a permanent basis, until 1969, although he did help out in a voluntary capacity for some months before he returned to the permanent staff. However, the exact timing is of no significance because Semple admitted to the police that he

16 KIN 71411.

followed R 7 into the bathroom because he fancied the boy, then rubbed R 7's private parts and his bottom while he was bathing, Semple then became aroused and pulled R 7 against him. Semple pleaded guilty to a single charge of gross indecency and was sentenced to two years imprisonment.

The Experiences of R 1

27 R 1 arrived in Kincora in February 1965 aged sixteen and a half, having been in Bawnmore Children's Home from the age of fourteen. Before that he had been in Manor House, Lisburn, from March 1961. Whilst in Manor House he behaved in a highly sexualised fashion, making sexual approaches to other boys and girls in the home.[17] He was moved from Manor House to Bawnmore aged fourteen, and we consider his time there in the Bawnmore chapter of this Report. What is significant about R 1's time in Bawnmore from the Kincora perspective is that he alleged that he was repeatedly sexually abused in Bawnmore by S 1, a member of the staff there. Whilst Mains denied having a sustained sexual relationship with S 1, he did admit that they had sex on one occasion in Mains bedroom in Kincora.[18] Although Mains denied that when R 1 was transferred to Kincora S 1 told him about having homosexual relations with R 1, we cannot exclude the strong possibility that some such remark about R 1 was made to Mains by S 1, given the highly sexualised behaviour by R 1 reported whilst he was at Manor House, and that S 1 and Mains had sex together.

28 R 1 knew R 7 when they both were in Bawnmore, and in his March 1980 police statement R 1 alleged that when he arrived in Kincora he was warned by R 7 to watch out for Mains and Semple because they would interfere with him. He went on to say that a few days later Mains called him into his room and asked R 1 to masturbate him, saying that he had been told that R 1 did that sort of thing. Although R 1 initially refused he did masturbate Mains, who felt his testicles. According to R 1 this became an almost daily occurrence between them. Mains denied that any of these things happened, and maintained that position at his trial, where the prosecution decided not to proceed with the charges.

17 KIN 76471.
18 KIN 10479.

29 When considering the accuracy of R 1's account it is relevant that in February 1982 he spoke to Jim Cusack, a journalist on the Belfast Telegraph. On 8 March 1982 R 1 merely said that a journalist spoke to him at his home and asked if he knew "names of people mixed up in the Kincora situation. I told him that I did not".[19] Jim Cusack's account was that R 1 contacted him on the telephone on one or two occasions, saying that he (R 1) thought the information he had about Kincora, "might be worth money to him", mentioning £50 and then £30. He was told that it was not the policy of the newspaper to pay for information.[20] We mention this because one of the factors that has to be given due weight when assessing the reliability of the account given by any witness is whether the witness has profited, or sought to profit, from information he or she says they have. This is a relevant consideration when we consider the account given by R 1 about Mains involvement in an alleged vice ring in Bangor to which we refer later.

The Involvement of R 1 with Semple

30 Unlike the position between Mains and R 1, it is common ground that an active homosexual relationship developed between R 1 and Semple. This involved each having anal penetrative sex with the other on numerous occasions. Ultimately Semple pleaded guilty to two charges of buggery, and one of gross indecency, against R 1, and received an overall sentence of five years imprisonment. Semple's account to the police in his statement of 1 April 1980 was that the initial suggestion came from R 1 who came into his room, invited Semple to masturbate him and they then masturbated each other. On subsequent occasions they engaged in mutual masturbation, oral sex and anal intercourse.[21] R 1's account was that Semple made the initial approach to him, asking R 1 to masturbate him, saying that if R 1 could do it for Mains R 1 could do it for him. He also said that the anal sex started at Semple's instigation.[22] Whether R 1 or Semple initiated their sexual relationship, it certainly had a significant consensual aspect as it developed.

19 KIN 20568.
20 KIN 20570.
21 KIN 10357.
22 KIN 10141.

Semple's departure from Kincora

31 In February 1966 Semple resigned as assistant warden at Kincora, ostensibly for family reasons. However, in 1980 he admitted to the police that Mains spoke to him, saying that R 1 had told Mains what was happening between Semple and himself. Mains said that he told Semple this had to stop. Semple then stopped for about a week, but then resumed having sex with R 1. Again Mains called him in and told him to stop. Mains admitted that R 1 told him what was happening between himself and Semple. Mains knew that Semple's mother was unwell, so he suggested to Semple that he resign and Semple did so.[23] Whether Semple's mother was ill or not, this was clearly a convenient pretext that enabled Mains to force Semple out of Kincora. Given Mains's abuse of several boys both before and during Semple's first spell as assistant warden in Kincora we are in no doubt that Mains's objective in making it clear to Semple that Semple should resign was not to protect the boys in his care, but to avoid the risk of Semple's behaviour coming to light, and as a result imperilling Mains's position. Mains admitted that he did not tell his superiors what Semple had been doing; clearly he could not take the risk that his own sexual abuse of residents would come to light if he said what Semple was doing, with a result that he could lose his job and end up in prison.

The Experiences of KIN 4

32 KIN 4 first entered Kincora in March 1965 aged fifteen and five months, and remained for four months until he was discharged in July 1965. He was readmitted on an unknown date and remained in Kincora until he was discharged on his sixteenth birthday in September 1965. He was traced by the RUC during the Caskey Phase One investigation, and said that Mains came into the bathroom when he was naked, commented disparagingly on the size of his penis and patted KIN 4 on the backside. He made no other complaint about Mains. No charges were directed by the DPP in respect of his allegations, all of which Mains denied. KIN 4 commented that the talk amongst the boys was that Mains and Semple were "bent", and he referred to an occasion when he saw Semple lying on the beds in a room, although he did not witness any homosexual acts.

23 KIN 10415.

The Experiences of R 4

33 R 4 gave evidence to the Hughes Inquiry, and for consistency we refer to him by that designation, rather than as HIA 534, although he gave evidence to our Inquiry under both designations. He arrived in Kincora in August 1965 when he was about sixteen and three months of age, leaving fifteen months later in November 1966 aged seventeen and a half. Mains told the police that his first encounter with R 4 was when he bathed R 4 because R 4 would not wash, but he denied that anything else occurred. In 1980 during the Caskey Phase One investigation R 4 told the RUC that he regarded Mains as being like a father to him. He described how Mains got him to massage his bare back with cream in Mains bedroom. Nothing else happened at that time, but Mains asked him to massage his back with cream on other occasions, and on the second time Mains felt around R 4's genitals, although outside his trousers. The third time R 4 was in his pyjamas, and on this occasion was masturbated by Mains. The next time mutual masturbation occurred. This happened on other occasions, as well as oral sex. R 4 said he refused Mains request to have anal sex with him. These sexual acts all took place in Kincora, except on one occasion when the boys went on a summer camping holiday in Magilligan, Co Londonderry, when Mains performed oral sex on him when they were sharing a tent.

34 R 4 explained that his sexual relationship with Mains continued after R 4 left Kincora. He described how he returned to Kincora from time to time over many years. On these occasions he engaged in mutual masturbation with Mains, or Mains would perform oral sex on him. This practice lasted until Christmas 1979 when Mains allowed R 4 to stay in his home. R 4 described how they engaged in mutual masturbation, and Mains performed oral sex on him when Mains's girlfriend BAR 1 had gone to bed. By this time R 4 was 30.

35 R 4 explained that his sexual experiences were not confined to Mains, and he described engaging in mutual masturbation and/or anal intercourse with three other boys during his visits after he had left Kincora. One of these was R 9 who was in Kincora in the mid-seventies and said that he masturbated and performed oral sex on R 4 on one of R 4's visits to Kincora. R 4 also claimed he engaged in oral sex with R 17 in the garden of Kincora on one of his visits. R 17 denied that that occurred, although he did describe an occasion when he returned to Kincora, went out for a drink with R 4, and when they went back to the

hostel R 4 exposed himself to R 17 in the yard. R 17 said he just went back into the hostel and nothing occurred.[24] The third boy was R 18 who said he masturbated R 4 and then asked R 4 to masturbate him on one occasion when they were both in the living room at the front of Kincora.[25] As R 4 explained to the Hughes Inquiry, although he disliked what was happening when it started, "I just got used to it as a way of life".[26]

36 R 4 admitted that in later life he had a number of homosexual relationships with adult males, but none of these had any connection with Kincora. He also admitted sexually assaulting the eight-year-old-son of a family with whom he was lodging at the time; he was prosecuted for that offence in October 1981 and sentenced to six months imprisonment.

37 Given that Mains did not admit the allegations made by R 4, but had admitted to other similar offences, and that the circumstances of the alleged offence committed by Mains against R 4 would have been highly unlikely to have resulted in an increased sentence for Mains, it is understandable that the DPP did not direct a prosecution of Mains based on the allegations by R 4.

38 The description of his experiences by R 4 are significant for a number of reasons, not just because he was one of several boys who returned to Kincora for visits after they left. Given that for many it was the last childhood home they had, return visits were not surprising. We heard of similar instances of former residents of other children's homes doing so in homes we investigated, as well as keeping in touch with staff, even though in some cases they had been abused in one form or another in the home. What was different in the case of R 4 was that on some of his return visits he engaged in consensual homosexual activity with Mains, which took place over many years in Kincora itself, and on some visits he also engaged in consensual homosexual activity with residents. R 4 was therefore one of those ex-residents who returned to the hostel, and when they did so had sex with Mains, and with adolescent residents in Kincora who were willing to do so.

The Experiences of KIN 5

39 KIN 5 was admitted to Kincora for the first time in September 1965 when he was fifteen and a half, and he remained there for almost nineteen

24 KIN 11269.
25 KIN 10163.
26 KIN 71378.

months before being discharged aged seventeen at the beginning of April 1967. He was readmitted a week later and remained for a further three weeks. He described how he was in the bath during his first week in Kincora when Mains came in, asked why he was skinny, then put his hand into the water and pulled back KIN 5's foreskin before leaving the bathroom. On another occasion he said he walked into Mains's office to find Mains and R 4 kissing.

40 He remarked that it was a well known fact in the hostel that Mains was homosexual, and as we shall see it was in 1967 that the first recorded complaint about Mains's behaviour was made and investigated, although an earlier complaint may have been made in 1966. The 1967 complaint, and the evidence of KIN 5 and KIN 4, suggests that although Mains may have been successful in earlier years in concealing his homosexual desires and approaches to adolescent boys, he was becoming more open in his sexual approaches and this was becoming known to at least some of the boys in the hostel, although, as we shall see, not all boys seem to have been aware of what was happening. The evidence of KIN 5 was also significant because he refers to sexual behaviour by two other residents, KIN 12 and KIN 11 with whom he shared a room.

41 In addition, KIN 5 alleged that when on one occasion Mains blamed him for stealing some money, Mains punched him several times, knocking him to the ground. KIN 5 alleged that this was seen by a cleaner who reported the episode, resulting in a visit by a named social worker. The social worker could not be traced; both cleaners were interviewed and denied ever witnessing anyone being physically assaulted.

42 We will refer again to the experiences of other residents of Kincora during the second period, residents who told the police they were not abused in any way, nor were they aware of any homosexual activity in Kincora during their time there.

PART THREE

Period three: 28 February 1966 to 10 June 1969

43 This period of three years and three and a half months covers the time between Semple's resignation as assistant warden in 1966, and his reappointment to that post in 1969. Throughout that period Mains was again the only member of the care staff in the hostel, apart from a

five and a half month period in 1967 when KIN 66 was working as the assistant warden. KIN 66 took up his post on 26 June 1967 and worked in Kincora until 11 December 1967 when he went on sick leave. His employment was terminated on 19 January 1968, and we later examine the difficulties that faced Belfast Welfare Authority in obtaining a replacement for KIN 66. This meant that for the greater part of three years Mains was again on his own in Kincora, apart from the domestic staff. This had been increased to two with the appointment of a cleaner as well as the existing cook, and the two ladies continued to work in Kincora until it closed.

44 During this third period a total of 85 boys were admitted to Kincora, of whom seven alleged that at one stage or another they were abused by Mains. They included R 3, R 4 and KIN 5, and as we have already considered the accounts given by R 4 and KIN 5 it is unnecessary to refer to them again when considering this period. Although KIN 38 was in Kincora during this period, he said that he was abused in the next period we consider and so we leave him out of account during this period. In this portion of this chapter we concentrate on the accounts given by the four remaining individuals who say that they were abused during this period, starting with R 3. It is not entirely clear whether he was finally discharged from Kincora in August 1963, or, as the Hughes Inquiry believed, in May 1964. By Christmas 1965 he was certainly no longer a resident in Kincora and he was living in London. As we have earlier recorded, R 3 returned at Christmas for a number of years after he had been formally discharged from Kincora, and on those visits he stayed with Mains in Kincora. The Kincora registers show that one of those occasions was between 22 December 1965 and 22 January 1966, when R 3 had just turned twenty.

45 It is incorrect to regard R 3 as a resident of Kincora during this short stay because he was no longer the responsibility of Belfast Welfare Authority, and he does not allege that he was abused in any way by Mains during this period. His stay is relevant because it is an example of the practice of Mains allowing adult males to visit Kincora, and on some occasions to stay overnight. That was the case for R 3 who stayed in Kincora although he was no longer a resident. Nevertheless his stay was open and above board, being recorded in the register as "on holidays" and it does not seem to have been considered inappropriate.

The Experiences of R 5

46 R 5 was admitted to Kincora at the end of March 1965 when he was just over sixteen, and he remained there for eight months until he was discharged at the end of November 1965. He is of particular importance because he and R 6 were the first persons known to have complained to Belfast Welfare Authority about Mains, and we shall examine the response of the Welfare Authority to their complaints at a later stage. R 5 did not give evidence to the Hughes Inquiry, nor did he apply to our Inquiry, but as well as the letter he and R 6 sent we have the statement which R 5 made to the RUC during the Caskey Phase One investigation.

47 On 8 September 1967 R 5 wrote a two-page document he called a "statement" in which he made a number of allegations. The first was that on 16 July 1967, while the Kincora boys were at a camp, Mains was visited by two named men. One of these appears to have been R 2 who was by then a former resident of Kincora and who, as we have already seen, was in a continuing, if occasional, homosexual relationship with Mains after he left Kincora. The other was KIN 265. R 5 alleged that Mains sent the boys to their tents while he and his two visitors drank a considerable quantity of whiskey to judge by the number of bottles R 5 said he saw the next day.

48 In the statement R 5 also alleged that on 5 September 1967, that is three days before, KIN 66 the assistant warden accosted him while he was washing, saying "do I not get a kiss then". He then proceeded to feel all over R 5's body before putting his hand down R 5's underpants. R 5 said that the next day he told KIN 66 he was going to tell Mains all about him.[27] In a further entry he alleged that Mains made him wash dishes and sent him to bed early because R 5 had been associating with someone of whom Mains disapproved. He also alleged that on a different occasion Mains grabbed him and told him not to answer back. When R 5 was interviewed by the RUC in 1980 he gave a fuller account of the camp episode, repeating that whiskey had been drunk by Mains and the same visitors, but making no allegation about KIN 66.

49 Regarding Mains, R 5 said that when he had been at Kincora for six months or so he "realised there was something wrong as far as Mains was concerned". If R 5 is correct about the time he was describing, this would suggest that he came to this view around September 1967. He

27 KIN 11004.

described Mains coming into the washroom, putting his arms round the chests of the boys who were washing and holding them tightly against them. He also described Mains touching boys, including himself, on the behind as they walked past. Finally, he described one incident in the washroom when he was on his own washing himself whilst stripped to the waist. He said Mains came in, said "do I get a kiss then", put his arms around R 5 and then rubbed his hand up and down R 5's naked torso from the armpit to the waist. Mains then slid his hand down inside R 5's trousers. R 5 said he pulled Mains's hand away, told him to "F'-off", whereupon Mains walked out of the washroom. R 5 described this as happening before the camp episode.

50 In his police statement he described how he and R 6 went to Mr Ross of social services where he made the September 1967 statement. He said that when he and R 6 returned to Kincora and told Mains what they had done Mains became very angry. When R 5 said to Mains that Mains would not be hitting him again because he had reported him to the Welfare who would be coming to see him, and had told them everything, he said Mains became very frightened, giving them cigarettes, and, R 5 was nearly sure, money. He said that he remembered two people coming from the Welfare to see Mains, but he did not know what happened. About a month afterwards, he left Kincora.[28]

51 When questioned by the police Mains denied that anything sexual had occurred. He did admit pulling R 5's pants back in the bathroom to check whether R 5 had changed his underwear because he said R 5 did not change his clothes. Mains attributed the allegations to a personal grudge both boys had against him, although he admitted that he had used a cane to give R 5 "a hiding" because R 5 had approached the Welfare.[29] The DPP directed that Mains face one charge of indecent assault on R 5, but did not proceed with the charge when Mains maintained his plea of not guilty at the trial.

The Experiences of R 6

52 R 6 was admitted to Kincora in mid-August 1967 aged seventeen, and remained there for almost a year until he was discharged at the beginning of August 1968 when he turned eighteen. He therefore overlapped with R 5 in Kincora for four months, and so was not long into his stay when

28 KIN 10168 and 10169.
29 KIN 10421.

he and R 5 complained to the Belfast Welfare Authority. The RUC were not able to trace him in 1980, and so he did not give evidence to the Hughes Inquiry, and he did not apply to our Inquiry.

53 His allegations against Mains are to be found in a brief, hand-written statement. The hand writing and spelling are not good and suggest that R 6 may have had literacy problems. He made a number of allegations.

(1) On Friday 1 September 1967 Mains came into his room and felt around his body. He said Mains smelt of drink on this occasion.

(2) On Saturday 2 September Mains came to call him for work in his underpants and said "give me a kiss".

(3) On Wednesday 7 September while he was having a bath, Mains entered and said to him, "you look lovely in the water".

(4) On what would appear to be Thursday (although the day is mis-spelt and the date is given as Wednesday 7) he said Mains again said to him, "give me a kiss".

(5) Mains went out every Friday and Saturday night and got drunk.

(6) Apparently referring to KIN 66, because the name is mis-spelt, R 6 said KIN 66 told him Mains was very good at getting drunk;

(7) Told KIN 66 to watch what he said because Mains was a, "very bad man".[30]

54 When questioned by the police during the Caskey Phase One investigation in 1980 Mains denied these allegations, repeating that they were concocted by R 5 and R 6 because of a grudge, and there was nothing sexual in his actions.

The Experiences of R 8

55 R 8 was admitted to Kincora aged fifteen and two months at the end of April 1968, and remained there for three years and four months, leaving aged eighteen and five months at the beginning of August 1971. He therefore overlaps with the fourth period, but it would seem from his allegations made in 1971 that they happened before Semple resumed working in Kincora in September 1969. As we shall see, the allegations which R 8 made led to the second investigation by Belfast Welfare Authority into allegations about Mains and Kincora. R 8 did not give evidence to the Hughes Inquiry, nor did he apply to our Inquiry.

30 KIN 11039.

56 His account is contained in a five-page hand-written letter he wrote on 12 August 1971, which he sent with an almost identical copy to the Belfast Welfare Authority in August 1971. We shall consider later how the Welfare Authority reacted to these letters, but for present purposes it is sufficient to consider the form and content of the letter. In the letter, which is well written and detailed, R 8 made three specific allegations about the way Mains was running Kincora, as well as a further allegation about Mains's behaviour towards himself, and we consider that first.

57 R 8 described an occasion when Mains complained about having a sore back when he asked R 8 to rub his back, saying that if he did a good job Mains would pay him five shillings (25p). Given that R 8 was fifteen at the time and short of money he agreed. He then spent some time massaging Mains naked back, as Mains lay on the bed wearing only his underpants. Afterwards Mains invited him to share his bed for the night. R 8 got into bed with Mains, who was still presumably only wearing his underpants, but R 8 said that he kept his jeans on. He described how within a few minutes Mains put his arms around him and he heard Mains muttering, "on to it, on to it", whereupon R 8 ran to his own bedroom as fast as he could.

58 One of R 8's other allegations against Mains related to Mains attitude towards the sexual behaviour of other boys. He alleged that he and another boy KIN 67 had experienced an obvious sexual advance by R 34, another Kincora resident. When they told Mains his response was to say that R 34 would grow out of it. It was after R 8 reported this advance by R 34 to Mains that the massage episode described in the preceding paragraph occurred.

59 R 8 also alleged that another boy R 33 told him that he had a similar experience with Mains, although it is unclear whether this meant massaging Mains's back, or getting into bed with him, or both.

60 Finally, R 8 drew attention to R 2, who was by this time an ex-resident, returning to Kincora and spending the night with Mains's in his flat. He said that when he had gone into Mains flat one morning he found R 2 lying on the bed.[31]

61 R 8 was interviewed by the RUC in 1980 during the Caskey Phase One investigation. He said the incident when he got into Mains's bed occurred when he had been in Kincora for about a year, which if correct

31 KIN 11019.

would place it around March 1969. He also said that he had in fact spent the whole night in Mains's bed, and not just a few minutes as he had said in his 1971 statement. He explained that he could only assume that he had not admitted to spending the whole night in Mains bedroom then because he was too embarrassed to admit it.[32]

62 During the Caskey Phase Two investigation in 1982, following the publication of the final of the three articles in the *Irish Times* on 12, 13, 14 January 1982 by Ed Moloney and Andy Pollak, Ed Moloney gave D/Supt Caskey a transcript of an interview Moloney had carried out with R 8, in which R 8 appeared to confirm that the only occasion Mains made sexual advances to him was during the back massaging episode.[33]

63 When interviewed about R 8 by the RUC, Mains admitted that he had asked the boy to rub cream into his back. He explained that R 8 had come to him to complain about the advances made to him by R 34, that he had said to R 8 if he was frightened he could sleep in a chair, that R 8 did so but then got in to bed beside him. Mains had his trousers on and said nothing happened.

64 Although no charge was brought against Mains relating to R 8's allegations, it is clear from Mains's admissions that at the very least in 1967 he was sleeping with R 2 on a regular basis when R 2 visited and stayed overnight in Kincora. Contrary to what R 2 asserted, it seems that at least one boy, if not more, was aware of that liaison. Secondly, Mains was aware of sexual activity by some of the residents towards other residents, or consensual sexual activity between the residents.

The Experiences of KIN 13

65 KIN 13 came to Kincora in late March 1969 aged 16, and remained for four and a half months, until he was discharged in August 1969, just two months after Semple returned to Kincora as the assistant warden. Although KIN 13 did not allege that he had been the subject of any sexual approach by Semple, and had no complaints about Semple, he said there was general talk among the boys "That Raymond Semple and Joe Mains were homosexuals but I can't remember any particular incident referred to by any of them".[34]

32 KIN 10172.
33 KIN 21187.
34 KIN 10178.

66 KIN 13 did allege that on one occasion whilst a passenger in a car with Mains driving he was invited to steer the car. As he did so Mains first rubbed KIN 13's penis, before opening the front of KIN 13's trousers and masturbating him for a minute or two before stopping.[35] When Mains was questioned about this he said he may have taken KIN 13 out in his car, but not on his own, and this incident did not occur. The police pointed out to him that a similar allegation had been made against him by R 1 who had been in Kincora during the second period we have considered, but Mains replied, "no comment".

67 Before leaving the third period it is noteworthy that of the four boys who alleged they were sexually abused by Mains during this period, it was R 5 and R 6 who had the courage to contact the authorities, but, as we shall see later, their courage was for nothing as they were not believed.

PART FOUR

Period Four: 10 June 1969 to 22 June 1971

68 This short period of just over two years represents the period when Semple rejoined the care staff at Kincora as assistant warden, thereby returning the care staff to the complement of two on a long-term basis, and before McGrath was added to the care staff in the summer of 1971. During this two-year period, 38 boys were resident in Kincora, although some were admitted on more than one occasion. Of these 38, none claim to have been abused by Semple during this period, or for that matter during the rest of his time in Kincora. Of the 38 boys, we have already considered KIN 13 and R 8. Although they continued as residents in Kincora into this period, we have already considered the abuse that they described as occurring in the previous period. That leaves only two further residents who say that they were abused by Mains during this period, KIN 38 and KIN 27.

The Experiences of KIN 38

69 As we shall see when considering the last period, KIN 38 was in Kincora on two occasions. His first admission was in late April 1969 when he was fifteen and three months of age. He stayed for ten months until he was discharged aged sixteen and one month to join the Army. As

35 KIN 10179.

he said nothing happened to him during that period we now consider his experiences during his second period in Kincora. This lasted from early October 1971 when he was readmitted aged seventeen and nine months until he left three months later in mid-January 1972 just after his eighteenth birthday.

70 KIN 38 said that during his second time in Kincora he did various jobs for Mains and other members of Mains's family. He described how he was washing out a bathroom for Mains when Mains came in, told him to take down his trousers and then masturbated him. On another occasion a couple of weeks later Mains invited him to come with him to the Stormont Hotel. It seems both had a good deal to drink and certainly KIN 38 accepted he was drunk. When they returned to Kincora some hours later Mains invited KIN 38 to join him in bed; KIN 38 agreed and they engaged in mutual masturbation before they fell asleep.

71 KIN 38 said to the police in 1980 that he only agreed to this because Mains was in charge of the hostel and he was afraid of him.[36] Whether that was the case or not, Mains admitted they had gone drinking together, and although he could not remember KIN 38 staying in his bed, he agreed he probably did masturbate KIN 38. As this was a rather qualified admission by Mains, for the purposes of the criminal law and the necessary higher standard of proof, his admissions must be regarded as somewhat equivocal. KIN 38 was serving a sentence for robbery in England at the time of the Caskey Phase One investigation, and had apparently confessed to a murder in Northern Ireland in 1972. This was investigated by the RUC who considered that irregularities in his account and insufficient corroboration meant that there should not be a prosecution,[37] therefore it is not surprising that no prosecution was directed.

The Experiences of KIN 27

72 KIN 27 entered Kincora at the beginning of April 1971 aged fifteen and seven months of age and remained there for three months until early July 1971. Although his period in Kincora just overlaps with that of McGrath he does not make any allegations against McGrath. He said that when he entered Kincora the talk in the hostel was that Mains was homosexual. He said that on several occasions while he was

36 KIN 10181.
37 KIN 40091.

walking between the bathroom and his bedroom Mains patted him on the backside, and on one or two occasions slipped his hand inside the waistband of KIN 27's underpants. He also alleged that while making Mains's bed, Mains was obviously fondling himself.

73 He said that he had been caned on one occasion by Mains, and that he reported this and the sexual advances made by Mains to his female social worker but nothing was done. He reported these matters to her successor with the same result. The police were only able to trace the second social worker who said she did not remember any such complaints. Mains denied the sexual allegations, and he also denied the caning.

74 The DPP did not direct a prosecution, and given that the incidents had happened years before and were not corroborated by other witnesses, the decision was a reasonable one at the time.

75 It would seem from the accounts of KIN 38 and KIN 27 that, for whatever reason, Mains's sexual advances to the boys in Kincora during this period were less frequent and not as determined as in earlier years. Indeed, as we shall see, there is no evidence to suggest that he abused any more boys during the fifth and final period to which we now turn, that is the eight years and eight months from the arrival of McGrath in June 1971 until the suspension of Mains, Semple and McGrath on 4 March 1980.

PART FIVE

Period five: 22 June 1971 to 1980

76 During this period, 108 residents were admitted to Kincora. We have already considered the experiences of three of them, namely KIN 38, R 8 and KIN 27 whose accounts suggested that although their periods in Kincora extended into, and so overlapped with, period five, they were not abused by Mains during period five but only during period four. Apart from them, another 49 former residents were traced by the police during the Caskey Phase One/Two investigations or by the Sussex Police; 30 of the 49 made no allegations that they had been subjected to any form of sexual approach or abuse, whereas 19 alleged that they had been subjected to homosexual activity, or in one case to activity with clear homosexual overtones.

77 As we shall see, in later years nine former residents came forward, all were traced by the police, four of whom had been among the 49 former residents who had been traced earlier. Seven of the nine alleged that they had been abused, and two repeated that they had not been. As we shall see, some of those who had been interviewed as part of the Caskey Phase One and Phase Two investigations then gave further accounts of their experiences to those they had given during Caskey Phase One or Phase Two. We shall examine their accounts separately from the nineteen who alleged some form of homosexual contact or approach when they made their statements to the police in the early 1980s.

Allegations made against McGrath in Caskey Phases One and Two, and to Sussex Police

78 All those who were interviewed in the 1980s and said that they were abused during this fifth period told the police that they were only abused by McGrath, and it is to their accounts that we now turn. Given the numbers of those who made allegations, as well as the similarity of many of their accounts, we do not consider it necessary to refer to each and every account, or to every detail of those accounts. What we endeavour to convey in the following paragraphs is the full extent of McGrath's behaviour, and the salient aspects of the abuse he perpetrated.

McGrath's behaviour when waking boys in the Hostel

79 At the time of his appointment as a housefather at Kincora in June 1971, McGrath was living with his family at 4 Greenwood Avenue, just off the Upper Newtownards Road. This is a short distance further out of the city than Kincora. Not long afterwards McGrath and his family moved to 188 Upper Newtownards Road, a house very close to Kincora at 236. Although he was required to work at least 40 hours a week, McGrath was only required to live in during the absence of other staff on annual, sick, or other leave.[38] Although he was a non-resident member of staff, part of McGrath's duties required him to wake boys in the morning to get them ready to go out to work. As he lived so close to Kincora this was obviously not difficult for him.

38 KIN1215.

80 A number of the former residents traced by the police during the Caskey Phase One and Two investigations described how they would find McGrath's hand touching their private parts under the blankets as he woke them. A typical experience was that of Clinton Massey who waived his anonymity when he gave evidence to our inquiry on Day 209,[39] although he is referred to in the transcription as HIA 145 / R 11, being the inquiry designations and the designation given to him by the Hughes Inquiry. He did not speak to the Hughes Inquiry. He went to Kincora at the end of April 1973 aged fifteen and eight months, and remained there almost six months, leaving in late October aged sixteen and two months. He did not spend the entire six months in Kincora, because in June 1973 he went on a two-week camping trip with old friends from Marmion House in Holywood where he had been before he went to Kincora.

81 Mr Massey told the police in March 1980 that he was awoken by McGrath on two occasions in the morning to find McGrath with his hand under the bedclothes masturbating him. After that, McGrath would just tap him on the shoulder to wake him. In his inquiry statement, and in his oral evidence to us, Mr Massey said that he was "raped" in the morning almost every other day by McGrath who then made Mr Massey perform oral sex on him before ejaculating over his face. From this evidence to us it is clear that by "raped" Mr Massey meant being masturbated and being made to perform oral sex by McGrath. Although this account contradicts his 1980 police statement, which says that he was only masturbated twice by McGrath, there is no doubt that Mr Massey was sexually abused by McGrath, because McGrath pleaded guilty to a single charge of indecent assault on Mr Massey for which he was sentenced to two years imprisonment.

82 Another resident who woke to find McGrath's hand under the bedclothes was HIA 533, who was admitted to Kincora in late June 1976 when he was three months short of his sixteenth birthday. He remained there for fifteen months until he left in late September 1977 on his seventeenth birthday. He explained to the police in 1980 that after he had been in Kincora for a couple of months he woke to find a hand under the back of his underpants. He turned to find McGrath sitting on the bed with his hand under the bed clothes. HIA 533 was startled and pulled his body away. When McGrath left the room HIA 533 immediately got up and went

39 p.132.

to Mains's office to tell him what had happened. In the event Mains was not there, so it was a couple of hours before he was able to tell Mains what happened and that he felt like hitting McGrath.[40]

83 In 1980 Mains accepted to the police that HIA 533 had made such a complaint. HIA 533 said that Mains told him he would speak to McGrath and to ensure that McGrath did not do this again would arrange for the boys to be woken in future by the housekeeper. It appears that Mains did make that change, because the housekeeper told the police that Mains asked her to wake HIA 533, although he did not give her a reason. She pointed out that before McGrath was appointed she had woken the boys, and she said that about two years later she started to do so again at Mains's direction, although the reason Mains gave her was that another boy had complained to his mother that McGrath had told him to zip up his trousers.[41] Whether her recollection as to dates is entirely accurate or not, it is clear that Mains arranged for someone else to wake HIA 533 after HIA 533 complained to him.

84 Mains's account of the steps he took after HIA 533's complaint is significant because he claimed that he then became suspicious, and tried to watch McGrath and catch McGrath himself. Whether this is true or not, Mains did not report the allegation by HIA 533 against McGrath to his superiors as he ought to have done, nor does it seem he confronted McGrath, nor did he tell him not to do this again. **We regard these failures on his part as amounting to systemic failings by Mains.** Given his own behaviour with residents in the past, and his continuing homosexual relationship with R 2, Mains was not in a position to report McGrath lest his own crimes came to light in any subsequent investigation.

85 Another resident who told the police he experienced McGrath making a sexual approach to him under the bed clothes in this way was R 10. He came to Kincora in late March 1973 when he was fifteen and seven months of age, and stayed there for four years, leaving in mid-April 1977 aged nineteen and eight months. He told the police he got on well with Semple, as did other boys, and he said that Mains never made any advances to him. He said that about three or four weeks after he came to Kincora, which if correct would place the episode in April 1973, he

40 KIN10223.
41 KIN 40612.

felt a hand rubbing his inner thigh and moving towards his groin. He jumped up, saw that it was McGrath and told McGrath never to do that again. He said that when McGrath asked him that night why he panicked he replied that he would kill McGrath if he ever did that again.

Suspicions of other residents

86 R 10's experience confirmed what he had been told by other boys on arrival, namely that McGrath was homosexual and to beware of him. During this period several other residents said that they were given similar warnings. R 10 also said that during his years in Kincora there was talk among the boys that McGrath asked boys whether he could touch or caress them. Although R 10 was not approached again by McGrath, he said that he did not report this episode to Mains because he was scared of Mains, but he did warn others about McGrath.[42] Although he got on well with Semple and had a certain amount of respect for him, R 10 made no mention of telling Semple about this incident.

The Experiences of HIA 532

87 Other forms of behaviour on the part of McGrath with unmistakable sexual overtones, which would now be recognised as behaviour likely to lead to sexual abuse and would now be described as grooming, took the form of requests by him for boys to massage him, and approaches to boys while they were in the bathroom or using the toilet. One of the residents he approached in this way was HIA 532 who gave evidence to us on Day 208. He also gave evidence to the Hughes inquiry as B 1. HIA 532 had been in Bawnmore before he came to Kincora and we consider his experiences in Bawnmore in the Bawnmore chapter. He arrived in Kincora from Bawnmore in early April 1972 when he had just turned sixteen, and remained there for a year and four and a half months until late August 1973, when he was discharged aged seventeen and five months. He returned to Kincora two weeks later in early September, and stayed for seven weeks until he was discharged for a second time at the end of October. His third and final period in Kincora lasted two and a half months from early December 1973 until the end of February 1974, when he left a few weeks before his eighteenth birthday.

42 KIN10236.

88 HIA 532 described how he awoke to find McGrath's hand under the blankets trying to rub his penis. Despite telling McGrath to stop, HIA 532 said that McGrath behaved to him in this way throughout each of his three stays in Kincora. As McGrath only started working in Kincora in June 1971, and as HIA 532 first entered Kincora in early April 1972, he is the first known person to have been sexually abused by McGrath. His experiences of McGrath were not limited to these attempts to masturbate him in the early mornings, because he described one occasion when McGrath entered the bathroom when HIA 532 was only wearing a towel around his waist. McGrath locked the door, locked his arms around HIA before attempting to remove the towel and masturbate him, but HIA 532 managed to push him away and open the door and escape whereupon McGrath gave up.

Other forms of abuse by McGrath

89 McGrath did not confine his sexual behaviour to touching, or attempting to touch the penises of boys under the blankets. Several of those traced by the police alleged that he masturbated them, made them perform oral sex, and forced them to submit to anal rape. Eventually McGrath was charged with eighteen offences committed against eight individuals, and pleaded guilty to fifteen offences, two of buggery, five of gross indecency (that is masturbation or oral sex), and eight of indecent assault (or sexual touching). These fifteen offences covered his eight victims. Although McGrath only pleaded guilty to a single charge of buggery against two individuals, that should not be taken as meaning the prosecution accepted that this offence was committed only once against each of the two residents. All of the charges, and not just the buggery charges, appear to have been "specimen" or "sample" charges. Such charges are examples, so that it is unnecessary to have a separate charge relating to every one of what may be possibly a very large number of occasions when the same offence was committed during a particular period. This was, and continues to be, a common and proper approach by prosecution authorities.

The Experiences of HIA 409/R 14

90 HIA 409 gave evidence to the inquiry on Day 210. Although he also waived his anonymity he is referred to in the transcript by his R 14 designation. He also gave evidence to the Hughes Inquiry as R 14, and

so we shall refer to him as R 14 for the sake of consistency. R 14 came to Kincora aged sixteen and five months at the beginning of December 1974. He remained there until he left in June 1975 shortly before his seventeenth birthday. That includes a six-week period when he was not living in Kincora because he was remanded to Rathgael Training School under a place of safety order by the Juvenile Court. He was sent there for assessment after he had called at Palmerston Assessment Centre a few minutes walk from Kincora to see his brother. He struck his brother when his brother refused to join him on a visit to an uncle on the other side of the city.[43] Rathgael recommended that it was not a suitable place for him and R 14 was then returned by the court to Kincora, where he remained for a further four months until he was discharged in June 1975.

91 In his police statement he described, as he confirmed to our Inquiry, that initially McGrath came across as a caring, gentle and sympathetic man who often patted him on the head and asked him how he was doing. It was after R 14 was returned from Rathgael to Kincora that he was abused. He said the first sexual assault occurred around the beginning of March. He was having a bath with the door locked when McGrath tried the door and said he wanted something, so R 14 told him to wait. When he emerged from the bathroom wearing only a towel and went to the bedroom to fetch his clothes, McGrath followed him from the bedroom back into the bathroom and closed the door. He then exposed his penis and told R 14 that he was going to put this into him. When R 14 protested and said that he would tell Mains, McGrath replied that Mains would not listen to him, and he, McGrath, would hit R 14 if he did not cooperate. McGrath then made R 14 turn round grasp the toilet before he removed the towel and anally penetrated him for what R 14 thought was five or ten minutes. Before McGrath left, he told R 14 to keep quiet about it.

92 On four other occasions R 14 says McGrath forced him to submit to anal sex. One of these occasions was also in the toilet. On the other three times McGrath came to R 14 when he was in his bedroom. He says that the last occasion was the afternoon before he was due to leave Kincora for foster care and was packing. McGrath entered the bedroom and said he had heard R 14 was leaving. When R 14 replied that he was leaving McGrath said "One more time before you go". When R 14 refused,

43 KIN 76678.

McGrath threatened to tell his foster parents what R 14 was like and that he would tell them about the other times as well, presumably meaning that he would tell them that R 14 was homosexual. R 14 was scared, and obeyed McGrath when he was told to take down his trousers and lie face down on the bed. McGrath then anally raped him. There are other parts of R 14's experiences to which we shall refer later.

The Experiences of R 12

93 R 12 entered Kincora at the beginning of May 1973 aged seventeen and seven months, and stayed there for nine months until he left in January 1974 aged eighteen and three months. It would seem from the information available to the Inquiry that R 12 may have had learning difficulties, as he spent several years at a special school in Hillsborough before he went to Bawnmore where he spent a little over a year before going to Kincora.[44] He also appears to have spent a period in Muckamore Abbey Hospital (a hospital which treated children with special needs) after he left Kincora.[45] This would suggest that he was a particularly vulnerable individual.

94 R 12 was the subject of the other offence of buggery to which McGrath pleaded guilty, and as in the case of R 14, the buggery charge was a specimen charge. R 12 described to the police how the first such offence occurred when all the other residents were out. McGrath asked him to go to the toilet and when R 12 did so McGrath locked the door and told R 12 to take down his trousers and hold onto the toilet and he then anally raped him. He only stopped what he was doing because the doorbell rang. R 12 described another episode when McGrath invited him to the toilet and asked R 12 to masturbate him, which he did. The third incident involved McGrath following R 12 into the toilet, masturbating him and then getting R 12 to anally penetrate him before performing oral sex on him. The fourth and last episode occurred in the kitchen. At McGrath's direction they performed oral sex on each other before McGrath got R 12 to penetrate him.

95 The events we have described demonstrate several aspects of McGrath's behaviour. First of all, these events all occurred when R 12 was alone in the hostel at night. Secondly, McGrath appears to have picked on

44 KIN 10242.
45 KIN 10241.

someone who was particularly vulnerable because of his special needs. Thirdly, although R 12 said he did not like what he was doing, he did it because he was frightened of McGrath.

Complaints to Mains or Semple

96 We have described how Mains accepted that HIA 533 told him McGrath had put his hand under the bedclothes and touched his behind. It seems clear from a number of statements to the police during the Caskey Phase One and Phase Two investigations that other residents also complained to Semple. When Semple was questioned at the beginning of his first interview he volunteered that four residents whom he named had told him that McGrath had interfered with them by rubbing his hands down their pants.[46] In a later interview he claimed that "there were a lot of complaints about [McGrath] from the boys". When asked what was done about the complaints Semple replied that Mains spoke to McGrath, and "we tried to watch McGrath to stop this".[47] As we have seen, Mains admitted that after HIA 533 complained to him about McGrath he tried to watch McGrath himself to catch him, as well as arranging for the housekeeper instead of McGrath to wake HIA 533 in the mornings.

97 Semple's admission that he had received a number of complaints came as soon as the police started to question him in his first interview and we see no reason to disbelieve his account that some boys did complain to him, although none of the four he named as complaining to him told the police that they had done so. Mains also accepted that on at least one occasion a resident other than HIA 533 complained to him about McGrath. He said that R 15 complained to him that McGrath had grabbed him by the privates but said that Mains told him to forget it and that he (Mains) would see about it.[48] Mains admitted to the police that he had spoken to McGrath about this, and that McGrath told him that he told R 15 to pull up his zip and to tidy himself before going to school, and that he [McGrath] had touched R 15 on the front of the trousers. Mains also said that he reported this to Semple, to the two ladies on the domestic staff, and to R 15's social worker, although he could not remember her name.[49] McGrath did accept that Mains spoke to him about the complaint from R 15.[50]

46 KIN 10388.
47 KIN 10367.
48 KIN10256.
49 KIN10413.
50 KIN10512.

98 While it is not entirely clear who did complain, and there is no corroboration of Mains's assertion that he told Semple or other members of staff, we are satisfied that both Mains and Semple received specific complaints about McGrath's conduct from a number of boys, including HIA 533 and R 10. The nature of those complaints was such that we are satisfied that both Mains and Semple had good reason to believe that McGrath was sexually interfering with boys in the hostel, but failed to take sufficient steps to prevent this, other than replacing McGrath with one of the female staff on the waking-up duties. We are satisfied that neither reported these complaints or their suspicions to their superiors as they ought to have done, and their failure to do so was because they were inhibited by their own homosexual abuse of residents. **These failures to report McGrath were systemic failings by Mains and Semple.**

Consensual sexual activity in Kincora involving, and between, residents

99 Not all the homosexual activity in Kincora during period five involved residents who were pressurised or intimidated into engaging in sexual activity with McGrath. Some of the activity which took place involving him was plainly consensual, and there was also consensual sexual activity between the residents themselves. R 17 came to Kincora in early October 1974 when he was sixteen and seven months. He remained for a year and five months until he moved out in early March 1976. Two and a half months later he was readmitted at the end of May, and stayed for three months until the end of August 1976. He described to the police how McGrath approached him one night when they were alone in the hostel, and their sexual activity ended with McGrath getting R 17 to anally penetrate him. There were several other episodes when he described various forms of sexual activity taking place between himself and McGrath, including each penetrating the other. R 17 appears to have been a willing participant in these events, which he described as continuing for three nights a week for about two years.

100 R 17's sexual activity in Kincora was not confined to McGrath. He described one occasion when he was sitting in the television room with McGrath and another resident (R 9). McGrath was sitting between them and started to masturbate R 17 and R 9 at the same time, before leaving the room with R 9. R 9 made no such reference to such an episode in his police statement, and if it did occur this was the only

occasion that has come to light in Kincora in the course of the police investigations of the 1980s of more than two individuals being involved in any sexual activity in the presence of others.

101 Whether or not this incident did occur, it is clear that just as McGrath and R 17 carried on an intense sexual relationship in Kincora itself, and did so on a regular basis and throughout R 17's time there, there was also a continuing sexual relationship in the hostel between R 17 and R 9. R 17 said after the occasion when McGrath masturbated them both that he and R 9 engaged in anal sex about five nights a week, except for the weekends when R 17 went out.

102 R 9's account was somewhat different. He said that about two weeks after he entered Kincora in late October 1974 McGrath asked him to masturbate him, and then had anal sex with him. This happened on a great many occasions in R 9's bedroom and was clearly consensual. However, R 9 said that he and R 17 only had anal sex on three or four occasions. Whatever may be the truth about these particular accounts it is clear that others in the hostel knew of the sexual relationship between R 17 and R 9. Semple admitted that he was told by another resident, KIN 300, that he had seen R 17 and R 9 in bed together. KIN 300 was in Kincora from the end of July 1975 until mid-June 1976, so this incident must have occurred during that period. Semple told police that he had reported the sexual activity to Mains who said he would talk to the boys about it and therefore he (Semple) felt he had no more responsibility to the boys. Semple was pressed by the police about whether he had considered reporting the matter to the authorities and his response was revealing. He explained that he was embarrassed because he had been told off by Mains for having sex with R 1 in 1965 and therefore felt "how could I do a lot about it when boys told me about these sexual acts now".[51]

103 Another resident of Kincora who engaged in consensual sex with McGrath was R 18 whose background ranks as one of the most distressing histories of the hundreds considered by our Inquiry. He told the police his first sexual experience occurred aged eleven when he and a stranger engaged in oral sex in the toilets of a Dublin cinema.[52] Some years later when he was being allowed home from Lissue at weekends he described

51 KIN 10392.
52 KIN 10288.

how he frequented the toilets in Ward Park in Bangor and engaged in masturbation with men he met there. After Lissue he was moved to Ardmore School in Downpatrick. He said his next sexual experiences were when he came to Kincora. From mid-May 1977 until July 1977 he only stayed in Kincora at weekends while he was attending Ardmore. After July 1977, by which time he was fifteen, until March 1980, when he was seventeen and ten months, he was a full-time resident in Kincora. It would seem from his police statement that during the first weekends he asked McGrath to rub cream into his back because he was suffering from psoriasis. A few weeks later McGrath came into his bedroom after R 18 had a bath, massaged him, and then at McGrath's invitation R 18 masturbated him. A pattern then developed whereby he and McGrath engaged in mutual masturbation at weekends when the hostel was empty. This continued until McGrath was suspended in 1980.

104 While R 18 was clearly an active homosexual by the time he arrived in Kincora, he describes McGrath talking to him about religion and homosexuality, saying that some people naturally felt like that.[53] It would seem that whilst R 18 was a consensual partner in the sexual activity between himself and McGrath, there may have been a form of emotional bond between them. Whether that was the case or not, R 18 was sexually active during this period in Kincora because he told police that he had anal sex with two men during that time, although both episodes occurred outside the building. One involved a hairdresser who told the police they had only engaged in masturbation in his car outside the hostel when he left R 18 home. R 18 said he met the other man at a party and didn't know who he was. There is no evidence to suggest that any other person was involved in any way with bringing these people together.

105 During the police investigations Mains and Semple admitted various homosexual offences, some of which were committed with individuals who were no longer resident in Kincora when those offences occurred. McGrath denied all the allegations put to him. The DPP directed that a total of 33 charges be brought against them, and Mains, Semple and McGrath were sent for trial on 1 September 1981. Each of them pleaded not guilty to the individual charges against them on 27 November 1981, and their trial started on 10 December 1981 before Lord Lowry, the Lord Chief Justice of Northern Ireland. Mains and Semple then changed

53 KIN 10286.

their pleas to guilty on various charges. Semple admitted each of the four charges against him.[54] Mains admitted six of the eleven charges against him, and the prosecution accepted those pleas and entered a *nolle prosequi* on the five remaining charges, thereby effectively withdrawing them.[55] McGrath maintained his pleas of not guilty to all of the charges against him, and the first witnesses were called on the afternoon of 10 December.[56] The next day McGrath changed his pleas to guilty on fifteen of the eighteen charges against him, and the prosecution entered a *nolle prosequi* against him on the three remaining charges.

106 The decision of the prosecution not to proceed with a number of the charges against Mains and McGrath reflected their assessment of the difficulty of establishing those particular charges to the criminal standard of proof beyond reasonable doubt, and the decision to effectively withdraw the charges by entering a *nolle prosequi* was a normal and perfectly proper course for them to adopt.

107 We have not been able to gain a transcript of Lord Lowry's remarks when sentencing each of these men at Belfast Crown Court on 16 December 1981. As there were no appeals, a transcript was not prepared at the time. However a detailed report of these proceedings on 16 December 1981 appeared in the *Belfast Newsletter* of 17 December 1981 and contained some direct quotations from Lord Lowry's remarks.

108 The Lord Chief Justice took into account that each of the accused had pleaded guilty. Pleas of guilty had been long recognised as a mitigating factor resulting in an appropriate reduction in the sentence which would otherwise have been imposed had the accused been convicted after a plea of not guilty. In imposing the heaviest sentence on Mains, Lord Lowry pointed to Semple and McGrath as not being in similar positions of authority to Mains, because Mains held a very responsible post where the welfare, including the moral welfare, of the boys was entrusted to him. In distinguishing between the offences of buggery admitted by Mains, Semple and McGrath, the Lord Chief Justice applied another well established principle of sentencing, namely that the culpability of an offender who committed offences when in a more responsible position than his co-accused should receive a greater punishment than

54 KIN 101001.
55 KIN 101002.
56 KIN 101016.

the others. Making the sentences concurrent is the usual practice in cases where an accused commits more than one offence. The lower sentences for indecent assault and gross indecency were in accordance with the maximum sentence permitted by statute for both indecent assault and gross indecency being two years imprisonment at that time.

109 Lord Lowry referred to the sentences he imposed on Mains, Semple and McGrath when delivering the judgement of the Northern Ireland Court of Appeal in the case of *Spiers and Drake* (1982) 4 Northern Ireland Judgement Bulletins. That case concerned an appeal by two defendants who had pleaded guilty to offences of mutual masturbation, oral sex and buggery. Spiers, by then 58, had corrupted Drake, who was then 21, when Drake was 14 or 15. Drake was educationally sub-normal, went to a special school and then attended a club for mentally handicapped adults. The Court of Appeal upheld a sentence of five years imprisonment on Spiers on three charges of buggery, but because Drake was educationally sub-normal and immature, and because he had been corrupted by a long course of conduct with Spiers, his sentences were reduced from three years to two years imprisonment, all to run concurrently.

110 In that case Lord Lowry referred to a a decision of the English Court of Appeal in *Willis* (1975) 60 Criminal Appeal Reports 146. In that case, which was regarded as the leading case on sentencing for these offences at that time, Lord Justice Lawton observed:

> "In our judgement a sentencing bracket for offences which had neither aggravating nor mitigating factors is from 3-5 years and the place on the bracket will depend on age, intelligence and education. Few offences, however, have neither aggravating nor mitigating factors, many have both. When this happens the judge has to weigh what aggravates against what mitigates."

111 In page five of his judgement of the case of *Spiers and Drake* Lord Lowry referred to the cases of Mains, Semple and McGrath in the following passage.

> "Secondly, no two cases are exactly the same and comparisons between cases must proceed with extreme caution. The *Queen v. Semple* and others, heard recently in Belfast Crown Court, is an example of one of the aggravating features mentioned by Lord Justice Lawton, a breach of trust by those placed in positions of

responsibility towards young boys. The accused McGrath received a sentence of 4 years imprisonment, but his age, 65 and his cardiac condition were relevant factors justifying, or at least providing a basis for, a degree of leniency. The sentences of Semple and Mains thereafter had to relate to the sentence imposed on McGrath. It would have been possible to impose a heavier sentence on McGrath or to increase the differential between him and the other accused to reflect more strongly their lesser age, more robust health and greater degree of responsibility for boys under their control. These are difficult questions calling for an individual exercise of judgement..."

112 We have set out these passages to make it clear that the sentences of six years on Mains and four years on Semple and McGrath were entirely consistent with the relevant sentencing principles in both Northern Ireland and England and Wales at that time, and were at least as heavy as those that might have been passed in England and Wales. That may be seen by the following quotation from page 133 of the standard text book on sentencing at the time, the 1979 edition of *Principles of Sentencing* by D.A.Thomas:

> "The scale of fixed-term sentences extends from three years imprisonment to an upper limit of about 10 years, although in the majority of cases a sentence between three and five years will be appropriate. Longer sentences are likely to be upheld where the offence is aggravated by such elements as force or coercion, systematic seduction over a period of time, abuse of parental or other authority, or the extreme youth of the victim. Where factors such as these are present, either singularly or in combination, sentences up to ten years have been upheld, but more usually the sentence does not exceed seven years imprisonment."

Contemporary knowledge of abuse by Kincora residents

113 Over many years, allegations have been made in newspapers and on broadcast media that there was a homosexual vice ring centred on Kincora, and that a number of named individuals were involved. It has also been alleged that some of these individuals visited Kincora, or that residents of Kincora were made available to such people for homosexual purposes elsewhere. At this point we consider the information relating to these matters gathered in the various police investigations during the 1980s. As part of this process we have examined the accounts given by

the very large number of former residents of Kincora who were traced by the RUC and interviewed as part of the Caskey Phase One and Phase Two Investigations, and who were spoken to by the Sussex Police.

114 As is apparent from the accounts given by former residents to the police to which we have already referred, in the 1960s Mains and Semple appeared to have been successful in concealing their homosexual abuse of residents in Kincora from others. For a considerable period Mains also managed to keep secret his homosexual relationship with the former Kincora resident R 2 despite R 2 staying overnight in Kincora with him. However, as we have described, Mains was not completely successful in concealing his relationship with R 2. It would appear that by the early 1970s a number of residents had their suspicions that Mains, Semple and McGrath (after he joined the staff at Kincora) were each homosexual, and as we have already seen some residents were warned by others that they should be aware that one or more of the three were homosexual, and in particular that McGrath was thought to make homosexual advances to boys in the home.

115 That does not mean that every resident throughout the 22 years of Kincora's existence was aware during their time in the hostel that there was any form of homosexual activity taking place. During the first two periods that we have considered, that is from 1958 until Semple left in 1966, seventeen former residents were traced, ten of whom were abused in one way or another, including R 2 and R 3, although R 3 was unaware of the relationship between Mains and R 2 that continued after R 2 left. Of the others from the first period, KIN 3 was there for one and a half years and told the police he was unaware of any sexual abuse. Of the thirteen former residents from the second period, although seven said they were abused, eleven said they had no knowledge of the abuse. The other two did not express their views. In other words, some of those who were abused did not realise at the time that others had been, or were being, abused. In the third period from February 1966 to June 1969, of eighteen former residents traced, five were interfered with whilst sixteen expressed surprise at the allegations of the sexual abuse of others. This pattern was repeated during the fourth and fifth periods. Of twelve former residents traced from the fourth period between June 1969 and June 1971, only one said he had been abused, eleven said that they were unaware of the abuse. In the fifth and final period of eight and a half years when McGrath was present, of 49 former residents

who recounted their experiences to the RUC during Caskey Phases One and Two and to the Sussex Police, 38 said they were unaware of sexual abuse.

116 Taking the second to the fifth period together, of 92 former residents traced, 76 (or 88.33%) told the police they were surprised by the allegations of sexual abuse that were taking place during their time in Kincora, even though some of them had described how they themselves were abused, or had engaged in homosexual activity with others, whether with McGrath or other residents.

117 The overall picture of these accounts is that throughout Kincora's existence the great majority of the residents who were interviewed by the police were unaware at the time of what was going on in the hostel, and were very surprised at what had emerged afterwards. A few examples suffice. HIA 199 / R 3 who was in Kincora in the early 1960s emphasised to us that there was never any talk among the boys in his time of sexual matters involving Mains.[57] He said that Mains was very secretive and would always check to see that R 3 was out of Mains's bedroom and into his own bed by 6am in the morning before the housekeeper arrived.[58]

118 R 1 whose experiences of both Mains and Semple in the mid-1960s resulted in both men being convicted of offences relating to him, told the Sussex Police in 1982 that:

> "When I read of the goings on at Kincora in the press I was very surprised because when I was at Kincora I knew nothing of prostitution and homosexual relations with fellas outside the hostel. If that had been happening there I would [sic] known of it."[59]

119 Dr Harrison told us how one of the former residents whom she visited as a social worker in the 1970s, and who did not say that he had been abused, rang her from England when the allegations about Kincora emerged to check whether it was the same home that he had been in. She recounted how he was completely amazed that this could happen. They discussed this again when he came to Northern Ireland for a short time, and he said to her he did not have any knowledge of it. She described him as a very articulate, streetwise and astute boy who had

57 Day 209, p.120.
58 Day 209, p.117.
59 KIN 40624-40625.

told the police that he had heard rumours about McGrath inappropriately touching some boys.[60]

120 We must emphasise that it was not only the great majority of the residents, including some of those who had themselves been abused, who were unaware of what was happening to others. The two ladies who worked in Kincora as domestic staff, one of whom worked there throughout the entire time the home was open, told the police they were unaware of what was happening. It may seem strange that so many of those who were in and out of Kincora in various capacities were unaware of what was happening, but, as we have seen, there was a consistent pattern of Mains, Semple and McGrath being extremely careful to conceal in a number of ways what they were doing. First of all, they approached boys who were vulnerable, or who they thought might be easily intimidated. If their initial approaches were firmly rebuffed they generally would not approach that person again. If they did so, they went to considerable lengths to approach the boy when others were not around. As we have seen in Mains's case, he would ensure that other boys were asleep before he would bring a boy into his bedroom at night, and get the boy back to the boy's own bed before others woke or were about.

121 Singling out boys, and abusing them, when others were not about, was not difficult because the residents were normally working during the day. Clinton Massey was one of those abused. He appears in *Who framed Colin Wallace* as "Clinton Ferguson". He explained to our Inquiry that his job was working at the *Belfast Telegraph*. This was an evening newspaper at the time, and that meant that he did not leave Kincora to go to work until 9.30am or thereabouts, whereas the other boys were out before 8.00am, and those who worked in the shipyard were probably catching the bus at 7.00am.[61] His work meant that he often returned to the hostel after the evening meal, and he frequently went back to Marmion children's home in Holywood to spend time with his friends there, returning late to the hostel.[62] Others explained to the police that they would go out at night after work, and as a result, as R 18 explained to the police, the hostel was often empty at night.

60 Day 223, pp.87 to 89.
61 Day 209, p.184.
62 Day 209, p.175.

122 Because there were many occasions that there were no other residents in the building that meant there were many occasions when Mains, Semple or McGrath had the opportunity to engage in various forms of sexual activity, consensual or not, with boys when other boys were not about. During McGrath's time at Kincora he appears to have often worked in the evenings and in the mornings, when either Mains or Semple were not about, because the duties directly involving the supervision of the residents were shared by all three. However Mains had other administrative duties, and our impression is that more of the direct supervision of the residents in the 1970s was carried out by Semple or McGrath, and because of the way their duties were arranged McGrath was often on duty on his own.

Visits by outsiders to Kincora

123 Beginning with the report in the *Irish Independent* of 24 January 1980, which alleged that boys had been recruited for homosexual prostitution and that police reports had named a number of important Northern Ireland businessmen as being involved, allegations have been made by various journalists that there were regular visits to the hostel by men with what are described as "posh accents" and that politicians, judges, and senior officials from the security services were involved in abusing children in Kincora. One of the earliest of such allegations was contained in the first of the three articles that appeared in the *Irish Times* in January 1982, from which we have quoted in the previous chapter. In the article published on 12 January there appeared the following paragraphs:

> "The Northern Authorities blocked an RUC investigation into a homosexual prostitution ring in 1976 which involved British officials in the Northern Ireland Office, policemen, legal figures, business men and boys in care at the Kincora Boys Home and other homes run by the Eastern Health Board, *The Irish Times* has learned.
>
> According to thoroughly reliable sources, it was suspected that the ring involved at least seven men, two of whom were British civil servants on secondment to the Northern Ireland Office.
>
> The ring was believed to have been in existence for at least three years. There were also strong suggestions at the time that NIO officials involved in the affair, who had been transferred back to Britain had introduced some of their successors to the ring.

> Among others suspected of involvement in the ring were police officers, East Belfast businessmen and justices of the peace. In some cases their names were supplied to the police and in others they had been traced via car registration numbers supplied to the police."[63]

124 These and similar allegations have been ventilated in many different publications and broadcasts from then until the present day, as can be seen from the following online article by a *Sky News* journalist on 23 July 2015. He reported that he had interviewed Mr Massey who was reported to have said that "he saw many mysterious English men with posh accents who were regular visitors to the building". The article said:

> "Allegations have persisted for years that senior figures within the security services, British military and other VIPs had free reign to sexually abuse children at the home in the 1970s and 1980s".[64]

PART SIX

The Experiences of Gary Hoy

125 Another applicant to the Inquiry who described his experiences in Kincora to the police in the 1980s, and again more recently, was Gary Hoy. In normal circumstances we would refer to Mr Hoy by his inquiry designation. However, he has appeared on television and commented to journalists on a number of occasions in connection with his judicial review application, when he has given his name and been photographed. He was not given anonymity by the High Court in those proceedings. He has publicly identified himself with Kincora, and made public comments about his time there, as well as giving an account in the judicial review proceedings. These accounts do not coincide in many respects with accounts he has given of his time in Kincora on other occasions, and we decided that in those circumstances it would be misleading to consider his accounts without referring to him by name when his public appearances and comments appear to suggest that he is content to have his identity and his experiences disclosed to the public.

63 KIN 21312
64 KIN 112261.

126 As we explained in the previous chapter, Gary Hoy brought an application for judicial review which was dismissed by Mr Justice Treacy on 8 April 2016, and his appeal was also dismissed by the Court of Appeal on 27 May 2016. After Mr Justice Treacy delivered his judgment the Inquiry legal team contacted Mr Hoy on several occasions by letter and by text, as well as writing to his solicitors, asking him to meet the Inquiry legal team in order to make a formal witness statement, because the Kincora module was due to start very soon thereafter. After he failed to keep three appointments, a fourth and final offer was sent by letter to him asking him to consult with Inquiry counsel on 2 June with a view to giving evidence to the Inquiry on 9 June 2016. This appointment was not kept either, and as Mr Hoy had failed to keep four appointments we concluded that he did not wish to give evidence to the Inquiry.

127 Despite Mr Hoy's unwillingness to assist the Inquiry we have considered the various accounts that we know he has given of his experiences whilst he was a resident of Kincora. He was admitted to Kincora in early January 1978 aged sixteen years and three months, and was discharged ten months later in November 1978 to join the Army. By that time he was aged seventeen and one month. He made a statement to the RUC in March 1980, by which time he was eighteen and living in Belfast. He explained that he had been placed in care when he was seventeen because his father had been injured in a motorbike accident and could not look after his family. In that statement he said the following:

- No homosexual approaches were made to him by staff or boys in Kincora.
- He could remember that if the boys were slow to get up William McGrath would throw the bed clothes off and look at him.
- He explained that although McGrath made no approaches to him he felt that McGrath was "gay".
- He could remember R 18 putting cream on his face and in his hair, (and this may be for the psoriasis to which we have referred already), and that he was sometimes helped with that by Mains.
- He also wanted to point out that while Mains would claim in his work diary to have taken the boys out in the minibus on pleasure trips he never took them out at all.

128 It is unclear whether Mr Hoy was formally interviewed by the Sussex Police. There is a reference in the 1983 report by Superintendent

Harrison at paragraph 493 to him being aware of gossip and rumour about McGrath but there is no formal statement to that effect. It may be that, as Mr Hoy said in 2011, he was spoken to informally by Sussex police officers. Be that as it may, he contacted the PSNI in 2011, and a note was made in the PSNI occurrence enquiry log report system after a visit to his home that "He does not recall if he ever provided [English police officers to whom he spoke] with a statement or not. He does not remember if he was physically or sexually abused but he does report emotional trauma".[65]

129 On 8 January 2013 Mr Hoy gave a lengthy account of his experiences to the PSNI. A 157-page transcript was exhibited to the High Court as part of his judicial review application. The relevant parts of this are.

- He and his younger brother were admitted to Kincora together.
- He was nine when he entered and fifteen when he left, although he also said he couldn't remember what ages he was in Kincora.
- Mains physically abused him by slapping him with his hand for things such as not keeping his room tidy.
- He remembered McGrath pulling duvets off his bed, and off the beds of other boys, to wake them up in the morning.
- Sometimes when he came out of the shower wearing only a towel Semple would come over, take off the towel, then dry him all over.
- He described an incident where Semple took him to a house in north Belfast where there was an elderly man who made him perform oral sex although he said his memory of this episode was a "wee bit blurry".
- On one occasion he went with Mains to Mains's house in the Four Winds area of south Belfast when Mains emerged from the shower and then anally raped him.
- He described a second visit to the house where Mains made Mr Hoy perform oral sex upon him.
- He described an incident where he was accosted by a man, whom he named, at a point very close to Kincora. The man had a knife and forced him into the playing fields of the school grounds adjacent to Kincora. He said the man told him to remove his clothes, but he was able to escape after maybe twenty to thirty minutes. He

65 KIN 60050.

did not describe any sexual assault, although his account clearly implies that this may have been intended.

130 On 18 February 2013 Mr Hoy spoke to the Inquiry Acknowledgement Forum. Transcripts of such accounts are normally made available to the Inquiry legal team to prepare a draft witness statement for the witness to consider. We examined the transcript to ensure that we had as complete a picture as possible of what Mr Hoy has said about his time in Kincora. His account to the Acknowledgement Forum was broadly the same as that which he gave to the PSNI some weeks earlier.

131 It will be apparent from this review of the various accounts that Mr Hoy has given over the years that he has said at different times that he was not abused in Kincora; that he could not remember being physically or sexually abused; that he was sexually abused by Mains; and that Semple behaved in a manner that is certainly open to the inference that there was a sexual motive behind his actions. For whatever reason Mr Hoy did not provide the Inquiry with a formal witness statement, nor did he accept our invitation to give evidence to us. In those circumstances we are unable to resolve the significant contradictions between these various accounts, and so we have left them out of account when we reach our conclusions about what did, or did not, happen in Kincora.

The Experiences of KIN 24

132 KIN 24 was another resident interviewed in the 1980s by the RUC and the Sussex Police. He did not apply to the Inquiry, but approached the PSNI in 2015 with fresh allegations. He came to Kincora in early September 1966 when he was fifteen and three months of age, and remained there for six months until he left aged fifteen and nine months early March 1967. He was therefore in Kincora during a period when Mains was the only member of the care staff in the hostel, because Semple had resigned at the end of February 1966, and KIN 66 did not start his short period as assistant warden until June 1967. KIN 24 first spoke to the RUC in March 1980, by which time he was 38. He recalled being in Kincora for approximately two or three months during which time the person in charge was Mains, although he referred to "another tall thin bloke who was middle aged [and who] was also about the premises but I can't remember if he worked there or not". In that statement he said he was never approached by any member of staff, or

boys, to do any homosexual act, and concluded his short statement "I can't recall hearing any talk about any acts of indecency going on".[66]

133 When seen by the Sussex Police at the end of June 1982, by which time he was 41, KIN 24 confirmed that he had nothing to add to his RUC statement. He also said that he had no knowledge of any prominent people of the type we have already described being connected with Kincora, with the staff and the boys, or of any boys from the hostel being involved in prostitution or a vice ring. He concluded this statement by saying "I was surprised when I heard such allegations, because to the best of my knowledge nothing like that was happening whilst I was at Kincora".[67]

134 In the summer of 2015 KIN 24 approached the PSNI with fresh allegations. On 25 August 2015 his account was recorded by the PSNI. In it he described two occasions when he brought Mains a cup of tea in the mornings as he had been asked to do. On the first occasion Mains, who was wearing nothing underneath his dressing grown, touched him on his genitals and had an erection. Mains then masturbated him and got KIN 24 to masturbate him as well. There were similar acts on a second occasion.

135 Although KIN 24's account of what happened on both occasions is in keeping with other allegations against Mains, and with Mains's admissions of his behaviour towards other boys, it is surprising that KIN 24 did not mention these events to the police in either 1980 or 1982. He told the police in 2015 that he told his father what had happened when his father came to Kincora to take him away, although he says his father did not react. KIN 24 later concluded that this may have been because his father was homosexual. Given that KIN 24 told his father when he was not yet 16 years old, we would have expected him to tell the PSNI and the Sussex Police about these events.

The Experiences of KIN 279

136 KIN 279 was the youngest of three brothers who were in Kincora for two weeks in late May and early June 1975. He and his twin brother were nine, and their older brother was there at the same time. KIN 279 was interviewed by the RUC in 1980 when he was thirteen, and again by the

66 KIN 11613.
67 KIN 40667.

Sussex police in June 1982, by which time he had just turned sixteen. On both occasions he said he was not interfered with, and was unaware of any indecent acts taking place. He told the Sussex Police that he too was unaware of any others being involved with the police, or of any prostitution ring involving boys from the hostel.

137 A police note of his initial contact with the PSNI in 2014 records that KIN 279 said that he had no memory of being abused until three and a half years before "when he fell off a roof and sustained a head injury".[68] At the start of his recorded interview he said that while working as a roofer he fell off a roof two and a half to three metres to the ground, but there wasn't anything broken. He went on to say that he developed what he described as "severe depression" and said that he saw a psychiatrist in Holland and was unable to work. He described being lifted out of bed in his pyjamas, he thinks by a man called Raymond, and then being brought to another room where he was placed on a table, penetrated by something and being subjected to oral sex. He said that he remembered McGrath being present, and seeing McGrath's exposed groin area.[69]

138 KIN 279 confirmed to Sussex Police more than 30 years before that he had not been abused in Kincora. His subsequent references to having a severe fall, a possible head injury, suffering from severe depression before recalling the events he described as happening almost 40 years before, his description of what appears to have been a violent and abusive family life before he and all his brothers and sisters were taken into care, and to undergoing psychiatric treatment, cast doubt on the reliability of his purported recall of the events he now describes.

The Experiences of KIN 135

139 KIN 135 arrived at Kincora at the beginning of January 1964 aged fifteen and one month, and left approximately seven months later in mid-August. In 2012 he contacted Greater Manchester Police and in due course gave a lengthy recorded interview in which he described his experiences in Kincora. During this interview he said that although he was aware in the past that police had been asking people to come forward who had been residents in Kincora he had been too ashamed and embarrassed to do so at the time.

68 KIN 60151.
69 KIN 60173-60207.

140 Altogether he described being raped by Mains about six times, by McGrath four or five times and once or twice by Semple. He described on one occasion Semple bringing him to Mains and then being made to perform oral sex on both. On another occasion after he had been in Kincora about six months, which would place these events around June 1964, he says Mains, Semple and McGrath took him from his bed to another bedroom. He was then slapped and punched while he felt fingers and then a penis entering his anus. On a third occasion he described being in the kitchen when McGrath took out his penis, grabbed him by the hair and forced his head down, but he was able to get away. He said that he ran away, but his father brought him back to Kincora. He said he was severely beaten by Mains, and threatened with being taken away and not being found again. He also described being regularly beaten. He said he was in Kincora for two or three years.

141 A number of aspects of these accounts cause us concern.

(1) KIN 135 was only in Kincora for seven months in 1964, not for two or three years.

(2) While Semple and Mains worked in Kincora during the time he was there, McGrath did not come to work in Kincora until June 1971. There is no evidence from any of the residents or elsewhere that McGrath was connected in any way whatever with Kincora in 1964.

(3) None of the other former residents who made allegations about Mains and Semple have alleged that each engaged in sexual abuse of residents in the presence of each other, or in the presence of McGrath, other than KIN 238.

(4) Other allegations which he made are at variance with accounts given by other residents, such as his allegation that Mains would ask boys to sit on his knee and then have an erection. If such a thing happened we would have expected others to have undergone similar experiences but no other person has made such an allegation.

The Experiences of KIN 238

142 KIN 238 was admitted to Kincora on 24 May 1977 just after his thirteenth birthday and remained there for eighteen days. It appears that the RUC attempted to contact him because he was a former resident at the time of the Caskey Phase One investigation but he was serving with the Army in Germany at that time. In 2003 he approached the RUC and made a

statement in September 2003.[70] In the statement he alleges that three incidents took place where he was sexually abused, and in the first of those he says he was physically abused as well. On the first occasion he was beaten by Mains because he was alleged to have stolen a pen. Another person, whom KIN 238 referred to as the house-master and who the police believed answered the description of McGrath, was there. He said that Mains told him to take down his trousers and bend over the house-master's knee. KIN 238 was then caned, after which he felt the house-master inserting his finger into his anus. When KIN 238 stood up and left he saw Mains sitting in his chair and masturbating.

143 On the second occasion he says that Mains and the house-master drove him to a house further down the Newtownards Road. All three were admitted to the house by a police officer in full uniform. All four went into the living room. KIN 238 was told to take off all of his clothes. He says that Mains and McGrath then masturbated. He says that McGrath then masturbated him and performed oral sex on him while Mains and the police officer were watching and masturbating. McGrath then made KIN 238 perform oral sex on Mains before anally penetrating KIN 238.

144 He alleged the third incident occurred when Mains and McGrath took him to the same house. The police officer was again present and KIN 238 said one of the men held him by the hair while KIN 238 was made to perform oral sex on all three men.

145 There are the following unusual features of these accounts.

(1) The presence of more than one abuser at the same time. Although KIN 135 also alleged that he was abused by two men in the presence of each other, that more than one abuser was present and also engaged in abuse, is a highly unusual allegation, although one that is not unique in this Inquiry.

(2) Our experience in this Inquiry, and the experience of a multitude of criminal cases, is that sexual abuse of this type is almost invariably performed in secret when only the abuser and the abused are present. It is unusual that more than two people are present.

(3) The weight of the evidence we have heard suggests that Mains and McGrath did not like each other, and it is surprising that either would abuse a boy while the other was present if they did not like or trust each other.

70 KIN 60459/60463

The Experiences of R 4

146 We have already described R 4's account that he gave of his experiences in the 1980s. In October 2015 he gave a tape recorded account of his experiences to the PSNI.[71] In that, he added to his previous account in a number of respects.

(1) He said that on two occasions Mains put his hand down and touched his privates, his penis and tried to play with him. Mains tried to kiss him on the lips but R 4 would not let him. Mains asked R 4 to touch him and he did. This would happen in the apartment beside Mains's office. R 4 stated that he did not discuss this with anybody at the time.

(2) During the summer while he was still a resident at Kincora, he went to Mains's girlfriend's (BAR 1) house to do some gardening. When he was there he alleged that Mains told him that he wanted to ride him and tried to touch him up.[72] When BAR 1 walked in, R 4 told her that Mains had tried to touch him up and had done it before in Kincora.[73] This allegation had not been made before.

(3) R 4 said that the reason he did not tell any adults about what was happening at the time was because he was too scared and they would not believe him.[74]

147 R 4 gave evidence to us on Day 213. He was in Kincora between the ages of sixteen and seventeen for some fifteen months from August 1965 until November 1966. He emphasised that because he did not have a job he sat around the hostel all day doing chores such as cleaning, washing up and gardening, which he enjoyed. After about six months, which would place this at about February or March 1966, he brought Mains a cup of tea to his room upstairs in the hostel. A few nights later Mains asked him to rub cream on his back. When R 4 did so Mains began to fondle his privates and his backside, but R 4 refused his request to take off his trousers. About a month later the same thing happened, but this time it resulted in mutual oral sex and masturbation. This became a regular occurrence between them and continued after he left Kincora. He described how he returned to see Mains at Kincora on many occasions, although with decreasing frequency, and his last visit

71 KIN 60091-60114.
72 KIN 60108.
73 KIN 60110-60111.
74 KIN 60112.

was at Christmas 1979. On that occasion he visited Mains's house. He said that Mains let him stay overnight, and when BAR 1 had gone to bed Mains performed oral sex on him and they masturbated each other.

148 He also accepted that on his return visits as an adult he engaged in consensual sex with boys who were still living in the hostel. These were R 8, who was in Kincora between April 1968 and August 1971, and R 18 who was there between 1977 and 1980. As we have earlier seen, R 18 admitted that sexual activity took place between himself and R 4 when R 4 visited the hostel.

149 In his oral evidence R 4 confirmed that during his time in Kincora Semple never made any sexual approaches to him, nor was there any talk among the boys of either Mains or Semple being homosexual, although he accepted that he, R 4, might have been seen kissing Mains.

150 R 4 also said that there was quite a strict regime in the hostel, and he described being beaten with a leather strap by one of the temporary assistants at that time (KIN 384). R 4 is one of the very few residents of Kincora who said that they were treated harshly in a physical way.

PART SEVEN

Richard Kerr's accounts of his experiences

151 Richard Kerr was not an applicant to the Inquiry, but it came to the Inquiry's attention that in recent years he has given a number of accounts to journalists in both written and broadcast interviews, and in those accounts he described the way he was treated in Kincora and elsewhere. Because of the significance of the allegations made by Mr Kerr about the way he was treated in Kincora, and in particular his assertion that he was taken to various addresses in Northern Ireland where he engaged in sexual activity with other men, Mr Kerr was invited to become a core participant in the Inquiry. He was also requested to provide a statement to the Inquiry confirming the account he had given in an affidavit made on behalf of Gary Hoy in the judicial review application, and setting out anything else he wished to say relevant to the Inquiry's work. The Inquiry made arrangements for him to fly from Dallas in the United States where he now lives to Northern Ireland at public expense. This was so he could consult with his legal representatives, provide a witness statement to the Inquiry, and consult with the Inquiry counsel and give evidence during the module relating to Kincora. Accommodation

was arranged for him in Northern Ireland, and the Inquiry also agreed to fly his aunt from England so that she could accompany him while he was in Northern Ireland.

152 At a very late stage he withdrew from his engagement with the Inquiry, despite the fact that by then his legal representatives had been provided with a substantial number of documents relating to him, and funding at the Inquiry's expense had been made available to his legal representatives to represent him. At the start of Day 211, when the Inquiry proceeded to examine over two days the material relating to Richard Kerr and the various accounts of his experiences that he has given, Christine Smith QC, Senior Counsel to the Inquiry, outlined in considerable detail the arrangements that were made to facilitate Mr Kerr coming to Northern Ireland to give evidence, the arrangements that the Inquiry made to achieve this and the circumstances which led up to his saying that he no longer wished to engage with the Inquiry.

153 Just before Mr Kerr was due to catch a flight from Dallas in the United States to Northern Ireland the Inquiry was notified by his legal representatives that he no longer wished to engage with the Inquiry and that they were withdrawing from representation for him, although the junior counsel and solicitor for whom the Inquiry had provided public funding had attended almost all of the Kincora hearings before that time. The next day his solicitors issued a lengthy statement on Mr Kerr's behalf, and whilst we accept that Mr Kerr put his name to this statement, the nature of the statement and the detail it provided leave us in no doubt that this represented the views of his legal representatives as much as it represented Mr Kerr's position. We do not intend to deal with this in any detail other than to highlight two matters. In that statement it was asserted that the Inquiry wished to conceal documents from Mr Kerr and his legal representatives. That was not correct: his legal representatives had been provided with over 700 pages of documents relating to Mr Kerr. They had accepted to the Inquiry that what the state agencies knew about the abuse perpetrated at Kincora, and the individuals perpetrating that abuse, or when they knew about it, were matters that are not within Mr Kerr's knowledge. The Inquiry had no reason to believe that Mr Kerr was able to speak of his own knowledge on the issues of state participation, and he and his legal representatives had been provided with all of the documents available to the Inquiry at that time that the Inquiry considered directly bore upon Mr Kerr or on matters that the Inquiry considered that Mr Kerr was in a position to speak about from his own knowledge.

154 We regret that Mr Kerr decided not to assist the Inquiry as a core participant, and that it did not receive a witness statement from him. However, given the nature of the issues raised by him on various occasions, we considered it was essential to examine these accounts, and to do so in the light of the other material available to the Inquiry in order to reach a conclusion upon the assertions made by or on behalf of Mr Kerr.

155 We took time during the Inquiry to carefully consider the statements Mr Kerr previously made to the police and to the media even though he chose not to give a statement to this Inquiry or give evidence in person before it. This was because Mr Kerr's statements to the media have made a significant contribution to the public perception that there was widespread sexual exploitation of boys in Kincora by prominent figures. We decided that we should examine Mr Kerr's statements in a detailed and comprehensive manner in order to ascertain as fully as possible whether they provided reliable evidence that such sexual exploitation and prostitution occurred in and/or was orchestrated through Kincora.

156 Mr Kerr has spoken to the media on many occasions, and the main headings of his allegations can be seen from a number of transcripts of interviews he has given to various media outlets. In the course of an interview given to Channel 4 television on 7 April 2015 he made a number of assertions.

(1) The first time that he was trafficked to London was in February 1977.

(2) He was taken to an apartment block known as Dolphin Square where he engaged in a sexual encounter "I could have been sixteen, fifteen, seventeen."[75]

(3) He was abused by Dr Morris Fraser in the Royal Victoria Hospital in Belfast when he was thirteen, "I was thirteen, Morris abused me, in his office, two or three times on those visits".[76]

157 On 18 July 2015 a now defunct website calling itself *exaronews.com* (Exaro) published an article in which, according to it, Richard Kerr named a number of people who, it was said, "were part of a cover-up of a paedophile network linked to Kincora boys home in Belfast, Northern Ireland". According to Kerr, there were:

(1) "Lord Mountbatten, a cousin of the Queen, great uncle to Prince Charles, Chief of the Defence staff from 1959 – 1965, murdered by the IRA in 1979.

75 KIN 117037.
76 KIN 117049.

(2) Sir Maurice Oldfield, Director of the Secret Intelligence Service, better known as MI6.

(3) Sir Anthony Blunt, Master of the Queen's Pictures, former officer in the Security Service, or MI5, who became a Russian spy.

(4) Sir Knox Cunningham, Unionist/Ulster Unionist MP, Parliamentary Private Secretary to Harold Macmillan the Prime Minister, and member of the Conservative party's national executive committee 1959/66."

158 This article did not give any basis for the assertions that any of these people were connected with Kincora, or were part of what is asserted to be "the cover-up of a paedophile network linked to Kincora boys' home". The article on the website continued:

> "Kerr who has been speaking to Exaro since August 2013, said previously that he was too scared to name names. Asked for his reaction to people who disbelieve his claims, Kerr said 'I am not here to try to prove it to them. I am here to tell what happened to me, and I know it happened to me and I know it happened to those other boys'.

Later in the same article the website states:

> "During the interview with the programme's Ross Coulthart, Kerr also picks out other powerful people as members of the paedophile network who sexually abused him while he was a Kincora boy;
>
> - Sir Peter Hayman, Deputy Director of MI6, previously the UK's High Commissioner to Canada,
> - Sir Nicholas Fairbairn, Conservative MP, solicitor general in Scotland,
> - Sir Cyril Smyth, Liberal MP, assaulted him in Manchester.
>
> All the men named are dead, but Kerr remained fearful about identifying them. Kerr agreed to identify the men on camera, but was unwilling to say more about some of them."

159 The article continues:

> "An intelligence source told Exaro that Mountbatten mixed with paedophiles who went to parties in the Republic of Ireland.
>
> Mountbatten is also understood to have visited Kincora, although why remains unclear.

> Kerr tells *60-minutes* that he walked in on a meeting at Kincora between Oldfield and Joseph Mains, the warden of the children's home. He says that Mains immediately and forcefully ordered him out of the room. Mains was subsequently, in 1981, jailed for six years for sexual offences against boys.
>
> Kerr did not know at the time who Oldfield was, he says, and does not suggest that he abused Kincora boys.
>
> Kerr says that he recognised Blunt from his time at Kincora as one of a group of three men, the other two men sexually abused him as a boy, he says, although Blunt did not."

160 These accounts are of limited value to the Inquiry because they provide no detail to substantiate the allegations, nor is it apparent how Richard Kerr came to recognise some of the individuals to whom he referred. The article says that:

> "He picked out from photographs a series of men connected with intelligence, military, and politics – and even the royal family some he identified as paedophiles themselves."

The Inquiry cannot say how the identification of these individuals was conducted as Mr Kerr has decided not to engage with the Inquiry.

161 On 16 February 2015 he swore an affidavit which was lodged in the High Court as part of the judicial review application brought against the Inquiry by Gary Hoy. As this was made on oath and prepared with the assistance of legal representation we treat it as a more definitive and detailed account of what Richard Kerr can or cannot say about his experiences in Kincora. We summarise these as follows:

- He was born on 12 May 1961.
- He was placed in care in Williamson House in Belfast where he says he was physically and sexually abused.[77]
- He moved from Williamson House to Kincora in 1975 aged fourteen. He had two more years left at school, although he implies that it was then that Mains got him a job as a bellboy at the Europa Hotel in the centre of Belfast.[78]
- Shortly after he arrived at Kincora Mains invited him into his bedroom, offered him whiskey, and they engaged in what Richard Kerr described as "fumbling around" each other's private parts.[79]

77 KIN 119501.
78 KIN 119501.
79 KIN 119502.

- There were more encounters like this, two or three times a week.[80]
- He said that when McGrath began to "fool with me (sexually abuse me), in the bathtub. I eventually told him to back off and I told Joe Mains about it and he stopped after that."[81]
- After a while Richard Kerr began to be taken to meet people in hotels in Larne and other places he could not recall. He continued "I remember going to a Hotel on the Upper Newtownards Road, I don't remember the name but it was not far from Kincora."
- He also said "when I worked in the Europa hotel sometimes men would come and take me to their rooms and abuse me".[82]
- He said there "was a time I went to Park Avenue Hotel with Mr Mains, Mr Semple, my friend Stephen and then I met other men, and I went to a room with someone and we had a sexual encounter. I cannot remember his name or the names of the others."[83]
- He says other people abused him who never gave their names. One drove a Rolls-Royce.[84]
- He met another man in his home, "some place off the Springfield Road", who he thought was an Army captain.[85]
- He referred to men coming to pick him up in their cars, saying "these things happened to me at different times, sometimes during the week and sometimes weekends. Since I went to school, I would come home early and then go to hotels. Sometime I would be in Joseph Mains bedroom. Sometimes on the weekends, in the evenings I would go to places like Larne, Bangor, Portrush".[86]
- On one occasion he was taken to the Kilwaughter House Hotel in Ballyclare: "I remember there was some trouble there and something went wrong. I am not exactly sure what happened but the manager of the hotel told us we had to leave."[87]
- He described being taken to a hotel in Portrush by Mains, being taken upstairs to a room where a man was waiting for him who made Richard Kerr perform anal sex on him.[88]

80 KIN 119502.
81 KIN 119502.
82 KIN 119502.
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84 KIN 119503.
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87 KIN 119503.
88 KIN 119503.

- He was subjected to extreme and degrading sexual abuse, including oral sex, penetration and other matters. These included him committing anal sex on others or being subjected to anal sex.[89]
- On one occasion he remembered coming home early from school "and I remember I walked into Joe Mains's office and there were three men there in suits sitting with Mr Semple and Mr Mains. They stopped talking as soon as I came in and I got the strong feeling I'd interrupted something secret and important. I would describe them as being shocked to see me."[90]
- He described people who he said were from the terrorist organisation the UVF coming to Kincora and said that he remembered being sexually abused by people he knew were members of the UVF.[91]
- He remembered being taken to the Harbour Inn Hotel in Larne with two men who picked him up from Kincora, being given a lot of alcohol so that he became drunk and they had sex with him. "On this one occasion I was arrested by the Larne police, who said I had stolen money from a hotel room".[92]
- While in Kincora he was given treats and presents, including chocolate and sometimes small amounts of money. "As I recall most of the perpetrators told me to keep quiet or they would put me away where I couldn't speak."[93]
- He says that he doesn't know how many other boys in Kincora were abused "but I know my friend Stephen was. There were other boys there who I believed were plants as they seemed not to fit in. They were two brothers aged around 18 or 19 and I now believe they may have been placed there by the security forces or security services to keep an eye on what was going on."
- He said that "the abuse stopped when I ended up in a court room due to being charged with theft, and sent to Rathgael remand centre. Around this time I stood in the Court room and told everybody I would tell everybody what was going on in Kincora if Joseph Mains did not come down to the Courthouse for me."[94]

89 KIN 119503.
90 KIN 119504.
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92 KIN 119504.
93 KIN 119504.
94 KIN 119505.

- He remembered being in a police station off the Holywood Road, and telling them about the abuse at Kincora. "I remember police officers who were friends with Joseph Mains hit me over the head with a telephone book and said 'what have you been saying?'".[95]
- He said "around this time my friend Stephen was sent to Rathgael. He ran away from Rathgael and got a boat to Liverpool. He was caught and put back on the boat to Belfast and he apparently jumped off the boat and died. I believe he committed suicide as a result of the abuse he had suffered, we had previously spoken about committing suicide together."[96]
- He said "after I left Kincora I was also abused at Borstal and then abused again when I was sent to Williamson House although I understand these proceedings do not relate to these institutions so I will not describe this in detail." He continued "when I left Williamson House I was told to stay in hotels. I remember a Social worker visited me at a hotel and told me I was 'an embarrassment to the government'. She also told me they had decided for me to go to England and stay with my aunt. They put me on a boat to Liverpool."

162 We will refer to these allegations later, but in order to do so it is necessary to examine in some detail the various events relating to Richard Kerr that can be established from the documents available to the Inquiry.

Richard Kerr's time in care

163 Richard Kerr was born on 12 May 1961 and was placed in care in 1966. Until he went to Kincora in July 1975 he remained in Williamson House. During that time he attended Harberton Special School for children assessed as educationally sub-normal by the EHSSB.[97] From the age of eleven until he left school he attended Mount Vernon Secondary School in north Belfast.[98]

164 He was fourteen when he moved from Williamson House to Kincora in July 1975, and therefore he was required to continue to attend school until he reached the school leaving age of sixteen. Kerr said in his affidavit that he once returned early from school. As he reached the

95 KIN 119505.
96 KIN 119505.
97 KIN 40170.
98 KIN 10194 and 10915.

age of sixteen in May 1977 that would suggest that he came back from Mount Vernon. Because that school was in a different part of Belfast, and assuming that he went by public transport, that would require him to get a bus from Kincora into the centre of Belfast and then out to Mount Vernon and then to retrace his journey in the same way after school.

165 A social worker's report prepared in 1979 said that he settled in well in Kincora, but was subdued and quiet during his first year there, staying in and playing cards and watching TV. The report also records that after he went to live in Kincora, "he settled in well and obtained a job as a porter in the Europa Hotel".[99] This, as does the passage from his affidavit quoted earlier, implies that he got the job in the Europa Hotel after he arrived in Kincora when he was only fourteen. That implication is not easily reconciled with the statement that he stayed in and played cards and was subdued during his first year in Kincora. It may therefore be that his employment at the Europa started after he reached school-leaving age in the summer of 1977, although we cannot exclude that he may have had some part-time employment there before that. As we shall see, when questioned by the police in October 1977 he was recorded as a "hotel porter" in his police statement,[100] and as working in the Europa hotel.[101]

166 In any event, not long after Richard Kerr left school in the summer of 1977, he was involved in several burglaries, as well as an attempted burglary, of a number of premises in residential areas not far from Kincora with Stephen Waring who also lived in Kincora.

Richard Kerr and Stephen Waring

167 Although the Inquiry referred to Stephen Waring by the designation R 37, which had been given to him by the Hughes Inquiry when examining Richard Kerr's evidence, we have decided to refer to Stephen Waring by his proper name in this Report for the following reasons. First of all, Richard Kerr and others have referred to Waring by name on several occasions and his name is therefore already in the public domain as a former resident of Kincora. Secondly, Richard Kerr referred to him as Stephen in his affidavit when he referred to his tragic drowning in the Irish

99 KIN 50885.
100 KIN 117562.
101 KIN 117553.

Sea in the passage already quoted, where he expressed his belief that Stephen Waring committed suicide as a result of the abuse Richard Kerr said he believed he had suffered in Kincora.[102] Therefore, given Richard Kerr's close friendship with Stephen Waring and that Stephen Waring's identity in connection with Kincora are already in the public domain, we decided that the need to present a clear and understandable narrative of these events in our Report outweighed the desirability of maintaining Stephen Waring's anonymity.

168 Stephen Waring was placed in Rathgael Training School after he was convicted of various offences of dishonesty in May and June 1974. His first contact with Kincora and with Richard Kerr appears to have occurred in February 1976 when Stephen Waring was on weekend release from Rathgael Training School. He became a full-time resident in Kincora in August 1976.[103]

169 In August 1977 Stephen Waring and Richard Kerr were held by the RUC at Musgrave Street RUC station in the centre of Belfast because they were found in possession of a diamond ring valued at £900.

170 On 22 September 1977 Richard Kerr and Stephen Waring went to Larne. According to Richard Kerr's police statement made at the time they went by taxi to the Kilwaughter House Hotel, arriving at 5pm and leaving at 7pm with two men they met there. Later that night they missed the last train to Belfast, and having unsuccessfully tried to get the police to contact the hostel, made their way to the harbour again to see if they could get a lift to Belfast. Eventually they entered a house and stole a bag, but it only contained school books. They were caught by the police shortly afterwards.[104]

171 On 26 September 1977 Robert Lindsey, a social worker, found a gold bracelet in Stephen Waring's wardrobe at Kincora, and this was reported to the police. Waring then absconded but was detained in London and returned to Kincora on 2 October 1977. On 4 October 1977 Richard Kerr and Stephen Waring were both questioned by DC Scully of Strandtown RUC. They admitted that they had committed a large number of burglaries in various parts of east Belfast stealing jewellery and money. Both were brought before the Juvenile Court and remanded in custody to Rathgael Training School until 14 October 1977.

102 KIN 119505.
103 KIN 40171.
104 KIN 117629.

172 On 14 October when he was again brought before the Juvenile Court Richard Kerr cut himself in the cells with a razor he had brought from Rathgael and managed to conceal from the authorities.[105] He and Stephen Waring again appeared before the court on 21 October 1977. Waring received a training school order committing him to Rathgael. Richard Kerr was able to persuade the court that he deserved a chance and his case was accordingly adjourned, and he was ordered to pay £5 a week as compensation to the owners of the stolen property that had not been recovered.[106]

173 Judging by the account Richard Kerr later gave to Dr Clenaghan, a psychiatrist who examined him in Rathgael on two occasions before producing a report on 20 December 1977, he was allowed to return to Kincora on 21 October 1977. However, he then stole £80 from Raymond Semple, taking £5 or £10 at a time to buy drink for two men who regularly took him out for the day from the hostel.[107]

174 Richard Kerr was therefore brought back to court and remanded in custody to Rathgael to see whether he was suitable for training school. Rathgael decided that he was not suitable, and recommended a period of Borstal training. The Juvenile Court sentenced Richard Kerr to a period of Borstal training, and he was then transferred to the male Borstal at Millisle outside Donaghadee, County Down which is the subject of a separate chapter of our Report. Although an appeal was brought against the order of the Juvenile Court sentencing him to a period of Borstal training, the appeal was unsuccessful, and except for a number of periods which he spent in hospital, Richard Kerr remained in the Borstal at Millisle until he was released in February 1979.[108]

175 In his report Dr Clenaghan recorded that on the first occasion he saw Richard Kerr he was feeling depressed, and talked at length about Stephen Waring and his tragic death. On the second visit Dr Clenaghan formed the view that Richard Kerr seemed to have got over this phase, and was more concerned about his own future. Dr Clenaghan concluded that Richard Kerr "tends to be easily led and influenced and is a slow learner".[109]

176 During his time in Borstal, Richard Kerr spent two lengthy periods in hospital. The first was from the beginning of February until the end of March 1978.

105 KIN 117574.
106 KIN 117573.
107 KIN 10915.
108 KIN 108011.
109 KIN 10916.

This came about because of a suicide attempt during which he inflicted a severe cut to his foot. This suicide attempt was made after his appeal was rejected. The nature of the injury was such that he required a period of skin grafting[110] and his stay in hospital was lengthened because he contracted smallpox.[111] He again attempted suicide on his return to Millisle, and between mid-April and mid-May was placed in the Psychiatric Wing of the Maze Prison. Altogether during this period he cut himself seven times.

Richard Kerr's Juvenile Court appearances

177 It is clear that Richard Kerr was extremely unhappy at being remanded to Rathgael in custody. His social worker recorded that when he was released on 21 October 1977 he "was very glad to be going back [to Kincora] because he had been desperately unhappy in Rathgael".[112] When he was remanded in custody to Rathgael again he wrote at least three times to Mains asking if Mains would come to see him, or come to court on his next remand. On 8 November 1977 he wrote:

> "I would like to go back to the hostel. Will you come up to court this Wednesday I am very sorry this time... It is up to the Welfare report. Please help".[113]

In his police statement of 25 February in 1980 he said "...while I was in Kincora from July 1975 to November 1977 I looked on Joe Mains as a father. I was very fond of him".[114] The tenor of the three letters he sent to Mains at this stage is that of an extremely unhappy sixteen and a half year old desperate to return to Kincora.

178 Mains did visit him in Rathgael, brought some sweets and other similar gifts for him, and told Mr Swann, the headmaster of the Reception Unit in Rathgael, that he was very concerned about Richard, and keen to have him back in Kincora. Whilst Mr Swann told the police in February 1990 that it was not unusual for hostel wardens to visit any of the boys in the reception unit, his impression was that the relationship between Mains and Richard Kerr "was closer than a staff/boy relationship, and this was borne out by comments by my members of staff who knew Richard and worked in his unit".[115]

110 KIN 108023.
111 KIN 11087.
112 KIN 11085.
113 KIN 119514 – 119515.
114 KIN 108010.
115 KIN 77183.

179 Richard Kerr's attitude towards Mains showed itself during the October Juvenile Court remand proceedings. Helen Gogarty, a trainee social worker, was Richard Kerr's social worker at the time. We will see in the next chapter how she was one of the social workers who later contacted Mr McKenna, whose article in the Irish Independent of 24 January 1980 brought the allegations about sexual abuse of residents in Kincora into the public domain. In her police statement of 13 February 1980, Helen Gogarty recounted how she spoke to Richard Kerr at the Juvenile Court at one of his remands prior to his conviction. He did not want to see her, and said "why isn't Joe Mains here?" She also visited him in Rathgael twice while he was on remand, and the only verbal response she got was "where is Joe Mains and when is he coming to see me and when am I getting out".[116]

180 The burglaries for which Richard Kerr was before the Juvenile Court were investigated by DC Scully of Strandtown RUC, which was a short distance from Kincora. DC Scully had visited Kincora in the past if some of the boys got into trouble, and he knew Mains. As the investigating officer he attended the Juvenile Court during the various remands, and spoke to Richard Kerr on several occasions over that time. DC Scully gave evidence to the Hughes Inquiry, and explained that on several occasions during their meetings, Richard Kerr demanded that he, Richard Kerr, speak to Mains, or that Mains should come to court. DC Scully said that he was suspicious of Mains because he had seen Mains in the company of R 2, whom he described as a well known homosexual, although at that time nobody had made any complaint to him about any homosexual conduct by either staff or residents in the hostel.[117] He thought Richard Kerr was effeminate, and had what he described as "the hall marks of a homosexual".[118] Because of his suspicions, and because of Richard Kerr's repeated demands to see Mains, DC Scully asked the prosecuting inspector at the Juvenile Court on the first remand to seek a remand of Richard Kerr to Rathgael in custody rather than allow him to return to Kincora on bail.[119] His application was successful.

116 KIN 78515.
117 KIN 73116.
118 KIN 73117.
119 KIN 73118.

181 At the next remand hearing on 14 October 1977 Richard Kerr again demanded that Mains be sent for, but when he was told that Mains refused to come, he was very angry, and said that if Mains did not come he would "tell all". When DC Scully asked him if he had any sort of relationship with Mains Richard Kerr laughed at him. When pressed as to what he meant by "tell all", Richard Kerr eventually told him that this meant that Mains gave him sherry in his private quarters late at night.[120]

182 DC Scully told Sgt Sillery, who was head of the Juvenile Liaison Branch at Strandtown RUC station, of his suspicions that Richard Kerr may have made the threats about Mains because there might be some connection between them of a homosexual nature.[121] We will return to this in the next chapter.

183 In his police statement on 26 February 1980 Richard Kerr said about this episode that:

> "When I made the threats about Joe Mains to the police and social workers that if he did not come to court I would tell all, I was referring to the drinks I had in his flat, that he knew about my break-ins and also about Mr McGrath's behaviour. I thought by making these threats he would come and help me because he would be scared. I never intended to tell but just to put pressure on Joe Mains to help me."[122]

184 He also described his relationship with Mains in the following way:

> "While I was in Kincora from July 1975 to November 1977 I looked on Joe Mains as a father. I was very fond of him. When I was doing break-ins he said to me that he knew I was doing them. He asked me to tell him the whole story about the break-ins and I told him part of it, that is about doing some break-ins.
>
> I looked up to and respected Joe Mains and while I was in his flat he did not touch me or say anything to me which would have suggested anything of a homosexual nature".[123]

He also explained that he wrote twice to Mains from the Borstal at Millisle, asking Mains to visit, and Mains did so.

120 KIN 73118.
121 KIN 73121
122 KIN 108010
123 KIN 108010

The death by drowning of Stephen Waring

185 At this stage it is appropriate to turn to the tragic circumstances of the death of Stephen Waring. Richard Kerr has referred to this in his affidavit lodged in the Hoy judicial review at paragraph 23.

> "Around this time my friend Stephen was sent to Rathgael. He ran away from Rathgael and got a boat to Liverpool. He was caught and put back on the boat to Belfast and he apparently jumped off the boat and died. I believe he committed suicide as a result of the abuse he suffered. We had previously spoken about committing suicide together."[124]

186 Richard Kerr's belief that Stephen Waring committed suicide because he had been subjected to abuse has been repeated on a number of occasions, as for example in a broadcast on BBC Radio Ulster on 12 March 2015 during an interview with the presenter Stephen Nolan. In this extract from the interview Nolan wrongly referred to Stephen Waring as Stephen Warren. Having referred to Colin Wallace, Richard Kerr continued:

> "The activities of the abuse increased when I went to the Europa. I started (unclear) night by working for these people and breaking into homes, with me, Stephen and Billy (unclear) they couldn't control it anymore. We got out of control...
>
> "Stephen Nolan: and this Richard is Stephen Warren who jumped to his death on a boat to Liverpool?
>
> Richard Kerr: Yes, maybe he came back too soon...
>
> Stephen Nolan: He killed himself?
>
> Richard Kerr: ...and that's what I don't understand today, why nobody's really investigating that. If he was confined, this is what the witness says, he was confined because he made threats that he was jumping over, he had alcohol in him, but (unclear) decided to let him go and run around on the front of the boat again. That does not make sense, (unclear)."

187 The circumstances leading up to Stephen Waring's death are more complex than these references would suggest, and were explained to

124 KIN 119505.

the Hughes Inquiry by Lindsay Conway. In 1977 he was the assistant welfare officer in Rathgael Training School, and in that capacity attended the Board of Trade Inquiry held on 9 February 1978 into Stephen Waring's death. Mr Conway explained to the Hughes Inquiry that Stephen Waring absconded from Rathgael on Friday 25 November 1977 and went to Liverpool with his elder brother. They were arrested when they were disembarking from the boat in Liverpool, were held by the authorities and then placed on the return sailing to Belfast. On Sunday 27 November 1977 the police reported to the training school that Stephen Waring had been lost overboard, and that although the ship carried out a search of waters near the Isle of Man, Stephen Waring was presumed drowned. Mr Conway told the Hughes Inquiry that the official finding of the Board of Trade Inquiry was "lost at sea, killed or drowned as a result of a fall from the vessel".[125]

188 Mr Conway was asked at the Hughes Inquiry,:

"Have you any reason to connect his death with his period in Kincora?

Answer: No. The evidence that was given to the Board of Trade inquiry was quite clear, that [Stephen Waring] was fooling about on the outer rail of the boat, that a soldier coming home on leave on two occasions pulled [Stephen Waring] in onto the right side, and that on the third occasion the soldier described that actually [Stephen Waring] slipped out of his grasp; so it was in no way a pre-meditated dash from any part of the boat over the side. The solider gave quite clear evidence that he'd been drinking heavily.

Chairman: That is what I was going to ask you. He had been drinking heavily?

Answer: He had been drinking heavily. Again the recollection is that it was a football supporter sort of return trip; it was a Liverpool match, and this was why the boys absconded, to go to the Liverpool match. When a number of the passengers had fallen asleep his brother recalled him going around and drinking the left-over's, so [Stephen Waring] was possibly drunk in this case, but the soldier recalled that he actually slipped out of his grasp."

125 KIN 73220.

189 At paragraph 4.197 of its Report the Hughes Inquiry stated that Stephen Waring's brother, to whom he was very close, accompanied him on the journey to Liverpool, and was sent back with him. He told the police that his brother had never mentioned anything to him with a homosexual connotation. He said his brother had been drinking heavily on the boat, and had threatened suicide, and he believed that his brother committed suicide due to a combination of being drunk and not wishing to return to Rathgael.[126]

190 Mr Conway's evidence to the Hughes Inquiry, and the account given of the evidence of Stephen Waring's brother, suggests that Stephen Waring may have committed suicide because he was drunk and did not wish to return to Rathgael, and that his tragic death had nothing to do with any homosexual activity as Richard Kerr has stated in recent years.

191 It is also significant that when Richard Kerr referred to Stephen Waring's death in his police statement of 25 February 1980, he said that whilst he and Stephen Waring had discussed committing suicide, he did not go on to attribute Waring's death to sexual abuse but to the pressure he said that they were under from another boy KIN 274 who he said had planned the break-ins which Stephen Waring and himself had then helped to carry out. He continued:

> "Stephen and I felt we were under pressure from [KIN 274] and we decided if we were caught we would go to London, take a lot of drink and then take an overdose of tablets. We were intending to commit suicide. It was Stephen who suggested suicide. I did not go to London and I didn't go out drinking with him or take tablets. We were both in Rathgael Training School when he escaped and I heard a short time later that he was supposed to have jumped overboard on the Liverpool boat."[127]

Richard Kerr and William Edmonds

192 During the same police statement Richard Kerr made references to a close relationship with a prison officer named Edmonds during his time in Borstal, and as a result the police decided to make further enquiries, even though Richard Kerr did not make any specific allegation.[128]

126 KIN 75292.
127 KIN 108012.
128 KIN 108004.

Edmonds was interviewed under caution by the police on 10 April 1980. He described how he worked as a hospital officer in Millisle Borstal giving out medicines and tending to minor injuries. He said that after Richard Kerr had been in Millisle for about six weeks, Edmonds saw him in the surgery for medical treatment. He described how Kerr was only wearing a dressing gown, whereupon Edmonds fondled Richard Kerr's genitals and buttocks. He then asked whether he could have anal sex, to which Richard Kerr agreed, but before Edmonds could perform the act they were disturbed by the arrival of another officer.[129] Subsequently he tried unsuccessfully to masturbate Richard Kerr in the surgery on a couple of occasions;[130] Richard Kerr was taken to Musgrave Park Hospital for a period and nothing occurred between them after he returned to Millisle.

193 He went on to say that Richard Kerr asked him to come to see him when he was released. About a year later he visited Richard Kerr in the Park Avenue Hotel, where he said Richard Kerr was staying at the time. On this occasion he described how they were interrupted as he was having anal sex with Richard Kerr by a phone call from the night porter saying that he had to go.[131]

194 When Richard Kerr was interviewed by the Sussex Police in 1982 he said that whilst nothing occurred between Edmonds and himself in Millisle, after he left Millisle Edmonds committed anal sex on him in Edmonds's home, and attempted to have sex with him twice after that, but Richard Kerr refused on each occasion. He said that he had not admitted this in 1980 because he had been too embarrassed, and because he thought the police were only interested in Kincora.[132] If Edmonds's version of events was correct, namely that the sexual encounter took place in the Park Avenue Hotel, that probably would have been during the period after Richard Kerr was moved from Williamson House to the Bishop's Court Hotel on 15 March, and before he left to go to Preston in Lancashire on 19 May 1979.

129 KIN 108018.
130 KIN 108019.
131 KIN 108019.
132 KIN 40796.

Richard Kerr's life in Northern Ireland after his release from Borstal

195 By the time Richard Kerr was discharged from Millisle Borstal on 9 February 1979 he had not lived in Kincora for some fifteen months since he was remanded in custody for stealing £80 from Raymond Semple. There was considerable difficulty in arranging somewhere for him to live, which was compounded by a dispute between social services and the Probation Board as to his care. Although Richard Kerr had been discharged from Borstal he was on licence, and so was the responsibility of the Probation Board. Social services were involved because the Probation Board asked the EHSSB to find accommodation for Richard Kerr. A serious dispute developed between the EHSSB and the Probation Board about Richard Kerr's behaviour, and about the most suitable accommodation for him, a position further complicated by the need for the Probation Board to find work for him. These disputes were examined by the Hughes Inquiry and it is unnecessary for our purposes to consider why they arose.

196 The dispute appears to have continued until Richard Kerr left Northern Ireland to go to live with his aunt in Preston in May 1979. Such was the dispute that the District Social Services Officer wrote to the Assistant Chief Probation Officer on 14 March 1979 expressing his concern.[133] By then Richard Kerr had been living in Williamson House for some weeks in what was clearly meant to be a temporary arrangement until more suitable accommodation could be found for him. It appears that bed and breakfast accommodation was not felt to be appropriate because all concerned believed that he needed a sheltered environment. Social services explored the possibility of a placement for him with the Corrymeela Community outside Ballycastle, Co Antrim. However, this was many miles away from Belfast and was obviously impracticable when social services learned that the probation officer had arranged a job at the Stormont Hotel in east Belfast for him.

197 The five weeks that Richard Kerr spent in Williamson House are significant for a number of reasons. Williamson House was a children's home, and although Richard Kerr was still legally within the age group that could be accommodated there, it was not really suitable because he was so much older than the children in the home, and on the face of

133 KIN 50882.

it a hostel such as Kincora would have been more suitable, as his social worker Mrs Kennedy confirmed to the Hughes Inquiry.[134] We shall refer to her again in the next chapter when considering her views at that time as to why Kincora was unsuitable.

198 Because there was no room for him in Williamson house, Richard Kerr was placed in the flat in the building occupied by Eric Witchell who was the officer in charge. Mrs Kennedy reported on 14 March 1979 that this arrangement was causing significant problems because of what she termed "the enormous demands", Richard Kerr was making on Eric Witchell's time. She said:

> "Eric is frequently up until the early hours of the morning talking to [Richard Kerr] and unless he actually leaves the house Eric's off duty time is usually interrupted by [Richard Kerr]".[135]

199 This was not the only problem because, as the District Social Services Officer wrote to the Assistant Chief Probation Officer in his letter of 14 March 1979, there were four areas of concern for the staff at Williamson House.

(1) Richard Kerr had returned home in a drunken state on a number of occasions; that happening three times in the last four days. On the last occasion he was brought from the Europa Hotel by a number of drunken men who caused such a fracas that the police were called.

(2) Both the residential staff and social work staff believed he was consorting with a number of men he previously knew in the Belfast area, that he was engaged in homosexual activity and had come into a considerable amount of money. There were "strong suspicions which suggest that the money was procured", that is that he had been paid for engaging in homosexual activity.[136]

(3) Richard Kerr had begun to talk again about committing suicide, which was of concern because of his previous history of suicide attempts.

(4) He was in contact with his sister who was also in care, and as a result his sister had taken considerable amounts of alcohol. There were also concerns about the nature of his relationship with his sister.

134 KIN 73596.
135 KIN 50887.
136 KIN 50882.

200 The District Social Services Officer said that Richard Kerr was obviously unhappy and unsettled in Williamson House, had been a most disruptive and disturbing influence, was now beyond the control of social services, and asked the Probation Board to take immediate steps to remove him to "a more suitable supervised environment to afford adequate protection for his safety and the safety of the children in our care."[137]

201 This letter appears to have been written following the report submitted to her superiors by Mrs Kennedy on the same day. She told the Hughes Inquiry that she had been up with Richard Kerr nearly every night that week, she felt that probation should be helping more, and "so the purpose of that report was to enlist the help of my senior management in settling that dispute, one way or another with probation".

202 In the event, although she had planned to put Richard Kerr into bed and breakfast accommodation, because he found the idea that intolerable she made a case for him to stay in a hotel,[138] and the next day, 15 March, she moved him to the Bishop's Court Hotel.[139] She said there were two moves before he went to Preston on 19 May.

203 The move to the Bishop's Court Hotel on the Upper Newtownards Road was to an address not far from Kincora, but that appears to have been a coincidence; there is no evidence to show that Richard Kerr had any contact with Kincora during this period between his release from Borstal in February and his going to Preston. At some stage before he went to Preston it seems that he moved to the Park Avenue Hotel from the Bishop's Court Hotel, because he told the police in 1980 that Edmonds visited him there twice after he left Kincora. It would seem that his stay in the Park Avenue Hotel was after he left the Bishop's Court Hotel.

Other causes of concern in 1977 about Richard Kerr's relationships

204 The concerns about Richard Kerr's homosexuality expressed in the letter of 14 March by the District Social Services Officer were not the only ones expressed in and around this time. As we have already seen, DC Scully considered that Richard Kerr had what he called "all the hallmarks of a homosexual" when dealing with the burglary investigations in October

137 KIN 50883.
138 KIN 73599.
139 KIN 73598.

1977.[140] His associations with the men with whom he travelled to Larne in October 1977 when he stole money from behind the reception desk in the Highways Hotel have also to be considered in this context. In his police statement in 1980 Richard Kerr said that while he was in Williamson House he got to know KIN 340 who visited his son in Williamson House and brought the boys sweets. KIN 341 drove KIN 340 to the home, and sometimes came in and spoke to the boys. Richard Kerr said he got to know them better when he was in Kincora, saying that he used to visit KIN 341's house and had drinks there. He said that the night he stole money from the hotel in Larne was the only night KIN 340 and KIN 341 collected him from Kincora. KIN 341 had hired a car for 24 hours.

205 Richard Kerr continued:

> "The three of us were out that evening for a drink. It was [KIN 341's] idea that we should go there for the Country and Western music. I went out with these older men because I had no friends and I knew them from their visits to Williamson House. There was no other reason – just as friends. They phoned me to Kincora and made the arrangements to go out. I had no prior arrangements with them."[141]

206 KIN 340 was interviewed by the police on 20 March 1980. By that time he was 37 years old. He said that he got to know Richard Kerr when his son was in Williamson House, and that Richard Kerr stayed on the settee on two or three occasions when KIN 340 was squatting in a house next door to Richard Kerr's family. He said Richard Kerr also visited him to take his dog out when he moved to another address. He described Richard Kerr contacting him whilst he was in Kincora to say that he wanted to hire a car. He claimed that Richard Kerr would arrange for KIN 341 to hire a car and would pay. This allegedly happened on about a dozen occasions, during which they went to several hotels, including the Park Avenue and Kilwaughter House and once to Kilkeel. On one occasion he said Kerr and he went to the Park Avenue Hotel, hired a room and played cards until 4am. He said that Richard Kerr always seemed to have lots of money, and bought the drink as well as paying for the car.[142] He denied that any homosexual activity occurred between Richard Kerr and himself.[143]

140 KIN 73117.
141 KIN 108010.
142 KIN 10199.
143 KIN 10200.

207 KIN 341 also made a police statement in 1980. By then he was 30 years old. He said that "on about two occasions" Richard Kerr provided the money for him to hire a car, and he then drove the three of them about. On the other occasions when the three went out together he said they went in his own car. One of those occasions was the night they went to Larne, although he wrongly called the hotel the Highwayman rather than the Highways. He claimed Richard Kerr "always seemed to have money and try [sic] to show off with the money though he was not a big spender". When he took the others out they would go to various hotels where they generally drank.[144] He said he only collected Richard Kerr from Kincora twice, and that was at Richard Kerr's suggestion. He said he never made any homosexual approaches to him.[145]

208 Whatever the true nature of the relationship between Richard Kerr and these two much older men, on any showing he was associating with them on many occasions and they were drinking together. If their accounts are to be believed, Richard Kerr had enough money to pay for their cars and drinks, something that would not normally be the case for a sixteen year old whose only income was his pay as a hotel porter. That these men were exploiting a teenager and not worrying about how he came by his money is incontrovertible. They were extremely unsuitable companions for Richard Kerr and that he was able to go on these expeditions is surprising. However, it must be recalled that Kincora was a hostel and not a children's home, and this could mean that boys might well get into unsuitable company outside the hostel without adverse comment from Mains or the other staff. It is noteworthy that when DC Scully came to Kincora on the morning of 4 October to speak to Richard Kerr he found him the worse for drink.

Richard Kerr and Eric Witchell

209 Eric Witchell was one of the six men who, including Mains, Semple and McGrath, were prosecuted for various sexual offences involving children who were in care and he was sentenced by Lord Lowry on 19 December 1981. Witchell, who was a member of an Anglican religious order, was sentenced to eight months imprisonment on each of six charges of indecent assault and gross indecency committed against three boys who were residents of Williamson House while he was in charge. The

144 KIN 10202.
145 KIN 10204.

prosecution did not proceed with a further charge of attempted buggery alleged to have been committed against one of the three boys.[146] As we explained in the previous chapter these offences were investigated as part of the Caskey Phase One investigations, which covered not just Kincora but several other institutions as well.

210 In his RUC statements of 25 and 26 February 1980 Richard Kerr referred to his time in Williamson House. He made no allegations that he had been subjected to any sexual abuse during his time there, although he volunteered at the end of his statement of 26 February that KIN 46 was found naked in bed in Williamson House with another boy, and was also found under a bed there with Richard Kerr's sister.[147]

211 Richard Kerr was interviewed by the Sussex Police and made a statement to them on 26 October 1982 when he said that during the time he stayed with Witchell in Witchell's flat in Williamson House, Witchell gave him alcohol and had anal sex with him three times. He said this was the first time he had anal sex. Witchell was questioned but denied these allegations. The police recommended no prosecution of Witchell, saying that whilst Richard Kerr may be telling the truth, there was no corroborative evidence to support his allegations, and as he had been interviewed twice in February 1980 and not made any allegation against Witchell his "reliability as a witness is extremely suspect".[148]

Richard Kerr's move to Preston

212 On 12 May 1979 Richard Kerr reached the age of eighteen, and so social services ceased to be responsible for him. On or about 19 May 1979 he left Northern Ireland and went to live with his maternal aunt in Preston in Lancashire. The possibility of his going to Preston appears to have been first raised almost eighteen months earlier during one of the remand hearings at Belfast Juvenile Court. In Mrs Gogarty's undated report she says that his "father was also there and the subject was brought up of [Richard Kerr] going to stay with Mrs Kerr's sister in Preston, Lancs". This implies that the suggestion was made by his father, and it commonly happens that when a teenager is before the courts in Northern Ireland having committed offences that may result in his being given a custodial sentence a parent would suggest that an alternative would be for him to

146 KIN 40221.
147 KIN 50863.
148 KIN 50848.

go to live with a relative elsewhere so that he could stay out of trouble. The magistrate requested a social report into the home circumstances of Richard Kerr's aunt in Preston, and adjourned the case for two weeks. However, when the case came back to court the report was unfavourable. Her accommodation, and other family commitments with another baby on the way, meant that although she was very concerned for him, his aunt was doubtful if she could help.[149]

213 The possibility of Richard Kerr moving to Preston appears to have been revived in April 1979. Mrs Kennedy, who was his social worker by that time, told the Hughes Inquiry that in April Richard Kerr went over to Preston "for a holiday and he decided he wanted to go back and settle there", which he did on or about 19 May when his hotel accommodation in Northern Ireland stopped.[150] In his police statement of 25 February 1980 Richard Kerr said that Mrs Kennedy gave him the money for his fare to Preston.[151] It is entirely probable that given his situation at the time he was provided with his fare to Preston.

Richard Kerr's time in Preston

214 In his statement of 25 February 1980 Richard Kerr said that in August 1979 he had met a man in Preston who he named. He said that by then he was having difficult times with his aunt so he moved into this man's house as a lodger, got a job and paid him rent. He then said "there is nothing going on between him and I".[152] However, when he was interviewed by Sussex Police in October 1982 he gave a different account of his relationship with this man, saying that he "and I maintained a homosexual relationship for two years, he didn't force me into the relationship".[153] Richard Kerr was now 21 and the statement concluded with him saying "I continue to have casual homosexual relationships in London where I live and work. I consider myself to be bi-sexual".[154]

Richard Kerr, Williamson House and Dr Morris Fraser

215 Dr Roderick Morrison Fraser, generally known as Dr Morris Fraser, graduated from the Queens University, Belfast, as a doctor and

149 KIN 11086.
150 KIN 73598.
151 KIN 108011.
152 KIN 108012.
153 KIN 50864.
154 KIN 50865.

subsequently specialised in child psychiatry, becoming a senior registrar at the Royal Belfast Hospital for Sick Children. On 17 May 1972 Dr Fraser pleaded guilty to a charge of sexually assaulting a child and was bound over for three years at Bow Street Magistrates Court in London. Following this, in 1973 he was brought before the Fitness to Practice Committee of the doctors' regulatory body, the General Medical Council. The Committee adjourned his case from time to time on the basis that he was receiving treatment. In July 1975 the committee determined that his response to treatment enabled them to feel satisfied that it would be proper to discharge him. The result was therefore that no disciplinary action was recorded against him.

216 On 12 July 2015 an article on Dr Fraser appeared on the website of the *Independent* newspaper pointing out that Dr Fraser had been allowed to practice after his conviction at Bow Street despite being convicted by a court in New York on other charges of sexual abuse. The article linked Dr Fraser to Kincora, and quoted Richard Kerr as saying:

> "I was 13. Morris abused me, in his office, two or three times on those visits. I will never forget that face. That black hair. I have never forgotten it. He was in contact with children's homes all over Belfast".[155]

217 Dr Niall Meehan is an academic in the Journalism and Media Faculty of Griffith College Dublin who has published a study of Dr Fraser and his career entitled *Morris Fraser, Child Abuse, Corruption and Collusion in Britain and Northern Ireland*. On 31 March 2016 Dr Meehan took part in a discussion of Dr Fraser and his activities on the BBC *Good Morning Ulster* radio programme. In that discussion he asserted that Fraser "dealt with children, everyday, and vulnerable children at that, and allocated them to institutions in Belfast, including Whiteabbey, Lissue Children's Hospital and also Kincora..."[156]

218 Richard Kerr was interviewed on the same programme later that morning. He described seeing Dr Fraser on two occasions in a hospital when he believed he was "probably about eleven or twelve". On the first occasion he was accompanied by his sister, but on the second occasion he said he was on his own. He said that he was being molested in Williamson House before that, and was wetting the bed. He said that Dr Fraser asked him to take down his shorts. Although he does not say

155 KIN 117049.
156 KIN 117052 and KIN 117053.

his genitals were exposed as a result, it is a reasonable inference that that was the position because he said that Dr Fraser took some pictures "with a kind of Polaroid camera".[157]

219 During the interview Richard Kerr also said that he believed Dr Fraser knew Mains. He said "…they all came up to Williamson House and they all had a meeting". He continued that two months later his sister was sent to Whiteabbey Training School for Girls:

> "…the next day I was taken out of Williamson House, by Joseph Mains in a car and taken up to Kincora at the age of fourteen. And Kincora was for working boys, not for boys that still go to secondary school".[158]

220 Dr Meehan sent a copy of his article on Dr Fraser to the Inquiry. In it, and in his contribution to the *Good Morning Ulster* programme, he raised a number of matters, including claims that the newspapers did not adequately report or investigate Dr Fraser's conduct following his conviction, and why Dr Fraser was able to continue working with children until he volunteered to stop by being voluntarily removed from the Medical Register in December 1995. These and a number of other matters raised by Dr Meehan about the way the medical authorities and the police dealt with Dr Fraser after his conviction in London are not matters that fall within the Terms of Reference of this Inquiry and we have not considered them. However, in this chapter we consider the allegations made by Richard Kerr relating to Dr Fraser in order to see whether he was ever treated by Dr Fraser, or, as Richard Kerr implied in the remarks quoted earlier, he was responsible for placing Richard Kerr or other children in Kincora.

221 The first thing we have to say is that, so far as we are aware, Richard Kerr never made such allegations about Dr Fraser before he took part in this programme on 31 March 2015. He made no reference whatever to Dr Fraser in his judicial review affidavit sworn on 16 February 2015, nor was it raised on his behalf by his legal representatives in subsequent correspondence with the Inquiry. His assertion that he was being abused in Williamson House before he says he went to see Dr Fraser when he was aged about eleven or twelve is difficult to reconcile with his failure to say that when he referred to sexual activity in Williamson House in the past in his police statement of 26 February 1980, or in the statement he made in 26 October 1982 to the Sussex Police.

157 KIN 117054.
158 KIN 117055.

222 In his statement of October 1982 the only reference he made to Williamson House was the allegation that Eric Witchell had anal intercourse with him on three occasions during the six weeks or so he spent in Williamson House after he was released from Borstal in February 1979, by which time he was not far short of his eighteenth birthday. If he had been abused during his period in Williamson House before he moved from there to Kincora in the summer of 1975 we would have expected him to have said so in that statement. In the same statement he did refer to an occasion aged fifteen when he was picked up by a man on the Springfield Road who took him to his house and put his hand on the inside of his leg. Given that by the time he made the statement in 1982, Richard Kerr was 21 and said in the statement that he continued to have casual sexual affairs in London and had described being the subject of anal sex with two different individuals after he was released from Borstal, it should not have embarrassed him to have discussed sexual matters relating to Williamson House. As we have already pointed out, he had made other allegations about sexual activity in Williamson House when he was interviewed in 1980 by the RUC.

223 Richard Kerr's medical records contain no reference to his being referred to Dr Fraser. His social services records show that after some months of disturbed behaviour in Williamson House, on 5 March 1975 he was referred to Dr Barcroft at the Child Guidance Clinic of Belfast's Royal Victoria Hospital.[159] Dr Barcroft attended a case conference at Williamson House on 6 May 1975.[160] The Inquiry requested that the Education Authority be contacted to see whether it held Richard Kerr's school records in case these would show if he was referred for psychiatric care by the school but we have been informed all his school records were routinely destroyed some years ago.[161]

224 He was examined by an educational psychologist in 1967 when he was living in Williamson House before he attended Harberton Special School.[162] It may well be that while he was living in Williamson House Richard Kerr was examined from time to time by an educational psychologist whilst he was attending Harberton Special School. In her report of 30 January 1979 his then social worker, Mrs Kennedy, noted "the last educational

159 KIN 119639 and 119653.
160 KIN 119726.
161 KIN 119736.
162 KIN 119633.

assessment of [Richard Kerr] was made in 1977 and concluded that he was capable of holding down a job".[163] This implies that he was assessed on more than one occasion. Following his reaching the school leaving age of sixteen in May 1977, on 18 July 1977 the Belfast Education and Library Board sent a pro-forma letter to Kincora stating that it intended to notify the [Eastern] Health and Social Services Board that it was in Richard Kerr's interest that "further care, treatment or supervision should be provided". The notice stated that amongst the advice received was that of the Senior Schools Psychologist.[164]

225 All of the available evidence suggests that Richard Kerr is mistaken in his belief that he was seen by Dr Fraser.

226 We have also considered the implication that Dr Fraser was in some way responsible for Richard Kerr being moved from Williamson House to Kincora when he was fourteen. That would have been in 1975. There is no evidence to suggest that Dr Fraser had any responsibility for, or involvement in, the decision that Richard Kerr be moved. Decisions as to whether a child in care in one institution should be moved to live in another institution were made by social services. In Richard Kerr's case it appears that the decision was approved by the District Social Services Officer.[165]

Richard Kerr and William McGrath

227 In his police statement of 25 February 1980 Richard Kerr stated that he looked up to and respected Mains, saying that "He did not touch me or say anything to me which would have suggested anything of a homosexual nature". He then said that McGrath "was known as a homosexual. Boys in the hostel had told me that he had tried it on them". He also said:

> "McGrath used to play around with me by pulling my jumper and wrestling with me. He would pull me close to him, his front to my back and press his belly up against me. It wasn't normal wrestling and I knew he was enjoying it in a homosexual way. The boys used to tell me that McGrath put his hands round their private parts. ...the boys told me that [Mains] had been told".[166]

163 KIN 117683.
164 KIN 119512.
165 KIN 12027.
166 KIN 10195.

However, in the judicial review affidavit of February 2015 he said that:

> "William McGrath began to fool with me (sexually abuse me), in the bath tub. I eventually told him to back off and I told Joe Mains about it and he stopped after that".[167]

This account is significantly different from his earlier account of McGrath's behaviour in his 1980 police statement.

Review of Richard Kerr's various accounts of his experiences

228 We have considered the information available to us in some detail because of the relevance of this information to the assertions that Richard Kerr has made in recent years about his experiences as a child in care, assertions which have not been confined to his time in Kincora. These assertions can be summarised by saying that he was abused by Dr Fraser during a hospital visit while he was resident in Williamson House, and that Dr Fraser was in some way instrumental in Richard Kerr being sent to Kincora when he was aged fourteen. He alleges that he was abused in Williamson House before he was moved to Kincora. During his time as a resident in Kincora he was abused there, and was taken to hotels where he was subjected to sexual abuse by various men. On other occasions he was collected from Kincora by various men. Eventually he was "trafficked" to London and sexually exploited there. It is clear from the various accounts that Richard Kerr has given in recent years, to which we have referred, that he asserts that not only was he sexually abused by Mains and McGrath in Kincora, but he was taken to other locations to be sexually exploited by homosexual men.

229 We should make it clear that the Terms of Reference of our Inquiry do not extend to what may have occurred when Richard Kerr was living in London or elsewhere, and we express no view on what he has said about his experiences in London or elsewhere, other than in respect of his move to Preston. If his allegations about his experiences in London or other parts of England are to be investigated that will be a matter for the Independent Inquiry into Child Sexual Abuse (the IICSA). As we have stated earlier, Richard Kerr was offered the opportunity to be a core participant in this Inquiry and was awarded legal representation to enable him to do so. His legal representatives were provided with

167 KIN 119502.

over 700 pages of documents relating to him. He did not provide the Inquiry with a statement, nor did he come to Northern Ireland. We have therefore had to assess his assertions on the basis of the material we have considered without having the benefit of whatever he might say to the Inquiry about these matters.

230 Based on our examination of the material to which we have referred we have reached the following conclusions:

(1) There is no evidence to support his assertion that he was ever examined by Dr Morris Fraser.

(2) There is no evidence to support his assertion that Dr Fraser played any part whatsoever in his move from Williamson House to Kincora.

(3) His assertions many years later that he was abused in Williamson House before he was transferred to Kincora contradict the reference he made in his RUC statement in 1980 when he referred to his time in Williamson House. It also contradicts his explicit statement to the RUC in 1980 that:

> "Before I left Northern Ireland and during the time I was in homes and other institutions I did not make any complaints about indecent behaviour by anyone to any members of the Welfare. There were no complaints to make". (emphasis added)[168]

This was one of the things that he confirmed in his statement to the Sussex Police in 1982 were true.[169]

(4) There is no evidence to support his claim that he was "trafficked to London" aged seventeen. The irrefutable evidence examined by us is that from 4 October 1977 until February 1979, except for the few days between 21 October and 7 November when he was on bail before being remanded back into custody when he stole from Semple, he was in secure custody in Rathgael Training School, and then in Millisle Borstal. He left Northern Ireland in mid-May 1979 when he reached the age of eighteen and was automatically discharged from care. He then made the decision to go and live with his aunt in Preston. After a few months living in Preston he formed a homosexual relationship with a man there and in October 1982 he told the Sussex Police he lived with this man for two

168 KIN 10196.
169 KIN 40796.

years. By the time Richard Kerr made that statement he was living in London, so that timeframe would suggest he stayed in Preston until some time in mid or late 1981, more than two years after he left Northern Ireland.

(5) The decision that he should leave Northern Ireland in May 1979 and go to Preston to live with his aunt was clearly his own decision. That possibility had been floated while he was on remand in 1977. Between his release from Borstal in February until he went to Preston in May social services found it extremely difficult to cope with him. By the time he went to Preston he was eighteen and there was nothing unusual about his being given his fare by his social worker to enable him to get to Preston. On 20 March 1979 the Assistant Chief Probation Officer commented in his response to the letter of 14 March from the District Social Service Officer to which we have already referred which outlined the difficulties caused by Richard Kerr's behaviour. He said:

> "No doubt, however, this young man will continue to be a headache for the Community and for agencies charged with his care and control. I would like to think we could contain him in the Community for a few more months even if a return to Borstal in the end proved inevitable".[170]

(6) As it transpired, Richard Kerr did not end up in Borstal again, but went of his own volition to live with his aunt in Preston.

(7) Although in 1980 he described McGrath's behaviour in a fashion that clearly had sexual overtones, he explicitly exonerated Mains from making any sexual approach to him. He confirmed this in his account to the Sussex Police in 1982. By then both Mains and McGrath had been imprisoned for sexual offences against residents in Kincora. It is therefore difficult to understand why Richard Kerr did not then make the allegations against them that he has since made more than thirty years after the event in his judicial review affidavit.

(8) We are satisfied that Richard Kerr was emotionally very close to Mains, and regarded him as a father figure. However, by 1982, Mains had been exposed as a sexual predator. Given that in 1982 Richard Kerr had described to the police how he was anally

170 KIN 11080.

penetrated by both Edmonds and Witchell, that he had lived with a man in a homosexual relationship for two years in Preston, and continued to have casual homosexual encounters in London. We consider it highly unlikely that he did not mention this matter because of embarrassment.

(9) Richard Kerr has also said that men came on various occasions to collect him from Kincora, that he was taken to the Park Avenue Hotel and to other hotels where he had sex with men. He has said that Mains took him to Portrush for this purpose on one occasion. He also described engaging in sexual activity with male guests in the Europa Hotel when he worked there. There is ample contemporary evidence in the material to which we have referred that he was associating with undesirable individuals, such as KIN 340 and KIN 341. At the least those two individuals were taking advantage of the surprising amount of money Richard Kerr had. When he was living in Williamson House the staff were clearly concerned that he was being paid for sex and that that accounted for his having a lot of money.

(10) As he told the police in 1980 he was drinking with KIN 340 and KIN 341 on their car trips to hotels. DC Scully found him the worse for wear from drink on 4 October 1977 when he came to question him about the burglaries. After his release from Borstal he came back drunk to Williamson House on several occasions.

(11) The picture that emerges from the contemporary information of Richard Kerr's life between 1977 and 1979 is that he was a highly vulnerable young man who was easily led and who craved attention. He was associating with older men outside Kincora who provided him with drink, and with other men who exploited his vulnerability to persuade him to agree to homosexual activity with them. Whilst this activity may have been consensual, it was nevertheless exploitive, abusive and illegal. There is nothing whatever to show that such behaviour was occurring in Kincora, or that Mains was arranging, or conniving at, sexual exploitation which appears to have been happening elsewhere.

(12) Richard Kerr appears to base his statement to the police that the security services or others were involved in his abuse on two matters. The first is that as a school boy he returned early to Kincora one day, walked into Mains's office and found Mains

and Semple with "three men in suits". He said he got the strong feeling he "had interrupted something secret and important, I would describe them as being shocked to see me".[171] He does not say that any of the three men spoke. As we shall see in the next chapter and as has already been confirmed by many of the other residents, officials from social services regularly visited Kincora during his time there. No doubt others did so in plain clothes, such as DC Scully. Any reputable visitor would have been surprised at a school boy entering the office and interrupting their business in that fashion. To infer from his description that he interrupted something improper is to place a sinister construction on the occasion without a shred of evidence to justify it.

(13) Up to and including his affidavit of February 2015 the only individuals Richard Kerr named as having performed any sexual acts on him were McGrath, Edmonds and Witchell. On the Exaro website in March 2015 he was reported to have picked out three individuals who, it was claimed, "sexually abused him while he was a Kincora boy". As he was only in Kincora between the ages of fourteen and seventeen this allegation can only relate to the period between his arrival at Kincora in July 1975 until he went into custody in November 1977. So far as we are aware, Richard Kerr has provided no evidence to support the allegations against the three men.

(14) One of the three men he named was the late Sir Cyril Smith, who was MP for Rochdale between 1972 and 1992. Sir Cyril Smith died in 2010, and since then allegations have been made that he was involved in the sexual abuse of children. On 27 November 2012 the Crown Prosecution Service in England and Wales stated that although investigations into allegations against Smith were undertaken in 1970, 1988 and 1999, he was not charged. The IICSA is investigating allegations relating to Sir Cyril Smith and it would be inappropriate for this Inquiry to make any comment on the allegations relating to him in England or Wales. None of the material this Inquiry has seen supports the apparent assertion made by Richard Kerr that he went to Manchester while he was a resident in Kincora between 1975 and 1977.

171 KIN 119504.

(15) Other than trips with the Boys' Brigade to camps at Bridlington in Yorkshire in June 1973 when he was twelve,[172] and to Southport in Lancashire in 1974 when he was thirteen, there are no records of any trips to Manchester or London, nor to his absconding for periods that would have enabled him to go to either place.

(16) Richard Kerr claims to have seen Sir Maurice Oldfield in Mains's office when he walked into a meeting. It is unclear whether this is the occasion already referred to when Richard Kerr says he entered Mains office to find Mains and Semple with three men in suits. We shall refer to Sir Maurice Oldfield in our chapter on the security services; it is sufficient to say at this stage that if there was such an episode involving Sir Maurice Oldfield, Richard Kerr did not identify him in his affidavit sworn in February 2015.

231 Richard Kerr's recent accounts of his experiences in Williamson House and Kincora are very substantially different from the detailed accounts he gave in the past. When these recent accounts are compared with the accounts he gave in the 1970s and 1980s, and with other documents from that era, a very different picture emerges from that which he now portrays. Having carefully examined all the material available to us we are satisfied that his more recent accounts are not to be relied upon.

232 We are satisfied that Mr Kerr was sexually exploited and abused as a boy and young man and are in no doubt that this had an adverse impact on his life. However, we cannot set aside or ignore the inconsistencies in his accounts of the abuse he said he suffered.

PART EIGHT

R 14

233 We now return to consider other aspect of the evidence given by R 14 as we said earlier that we would do. There are a number of matters which we will consider at this point. Before doing so, we record that McGrath pleaded guilty to one charge of buggery, one charge of indecent assault and one charge of gross indecency with R 14. There is therefore no doubt that R 14 was subjected to sexual abuse by McGrath.

172 KIN 119729.

234 R 14 discussed his experiences with the journalist Chris Moore, and appears as "Sammy", in chapter eight of Moore's book 'The Kincora Scandal'. R 14 told the Inquiry that he did not say to Moore, or if he did it was not true, that he had told a social worker about what had happened but she just laughed. He told us that he did not tell the social worker what had happened, nor was there an incident when the social worker called him in after raising his allegations with Mains and McGrath when McGrath called him a liar in front of the social worker, nor did Mains turn his back on him.[173]

235 Another matter relates to R 14's account to the Inquiry that McGrath put a gun in his mouth during one of his last sexual assaults upon him. He did not mention the gun incident to the police, nor did he mention the gun to Chris Moore who recorded him as saying that he was never aware of McGrath having a gun. When he gave evidence to the Hughes Inquiry he was legally represented and his own counsel asked him whether McGrath had threatened him in any way and he did not make any mention of the gun.

236 Finally, in his Inquiry statement he described another incident when he said Mains took him and two or three other boys to Bangor in the Kincora minibus. He said that Mains told them, "You're going to do what your told here". The other boys were sent in one by one, and when they came back they were crying. Before he could be sent into the hotel a police landrover pulled up nearby, and they were then taken back to Kincora. The clear implication is that this party of boys were taken to a hotel in Bangor by Mains for the purpose of, and were subjected to, sexual abuse. R 14 was not able to say why he never mentioned this episode to the police when he made his statement in 1980. He told us that he now believes the boys were abused in the hotel based upon what he heard years afterwards.[174]

237 We find it difficult to understand how R 14 did not tell the police about any of these three occasions when he gave his statements in 1980. They were all dramatic and plainly relevant to the police enquiries, notably the reference to his telling the social worker who then confronted Mains and McGrath with the allegations, allegations which were subsequently confirmed by McGrath's pleas of guilty to the offences against him.

173 Day 210, pp.32 to 34.
174 Day 210, pp.15 and 16.

The post-2000 allegations

238 The various allegations that have been made in recent years by those whose evidence we have examined in this section of this chapter are almost all materially different from the accounts they have given in the past. Where those accounts can be compared with contemporary records they are contradicted by those records. Some of the episodes described do not ring true, others are significantly different from the patterns of abuse described by many other residents. Taking all these matters into consideration we have come to the conclusion that we cannot regard the post-2000 accounts to which we have referred as sufficiently reliable to enable us to take them into account when reaching our conclusions about the way in which the residents were abused in Kincora.

Chapter 27:

Module 15 – Kincora Boys' Home

PART FIVE

PART SIX

PART SEVEN

PART EIGHT

PART NINE

PART TEN

PART ELEVEN

PART ONE

The Role of Social Services and the Police

1 In this Chapter we focus on the role of the Belfast Welfare Authority and its successor the Eastern Health and Social Services Board (EHSSB) in setting up, staffing and running the Kincora Boys' Hostel, as well as their roles in investigating complaints of sexual abuse of the boys who were resident in Kincora. As part of that process we examine the history of the hostel, the philosophy behind it during the 22 years of its operation, the way it was staffed and run, and the extent to which it was inspected by the Ministry of Home Affairs (MoHA) and its successor the Department of Health and Social Services (DHSS).

2 The way in which several complaints were dealt with by the Belfast Welfare Authority in 1967 and 1971, and by the EHSSB and the RUC on a number of other occasions during the 1970s, are closely interlinked. It therefore seemed sensible to consider all of these issues together. Although it will be necessary to make some reference to the role of the RUC Special Branch when examining the material relating to the RUC, because of the complex relationship between the RUC Special Branch and the Secret Intelligence Service (SIS), or MI6 as it is commonly called, the Security Service or MI5, British Army Intelligence, the Ministry of Defence, the Northern Ireland Office, and the Cabinet Office, it will be necessary to examine the actions of the RUC Special Branch in greater detail in the next chapter as well, and to that extent there will necessarily be some overlap between the two chapters.

The Hughes Inquiry

3 As we explained in a previous chapter, a committee under the chairmanship of His Honour William Hughes was set up in 1984 to examine allegations of sexual abuse of residents in a number of children's homes in Northern Ireland. Those Terms of Reference were somewhat different to ours. Nevertheless, the Hughes Inquiry thoroughly and comprehensively examined many of the issues relating to Kincora, and, as will become apparent, we have made considerable use of those parts of the transcripts of the relevant 60 days of public hearings of the Hughes Inquiry containing the evidence of witnesses which related to Kincora, as well as drawing heavily on those parts of the Hughes Inquiry Report dealing with Kincora.

4 More than thirty years have elapsed since the Hughes Inquiry. Many of the individuals who gave evidence to that Inquiry and whose evidence is relevant to Kincora are no longer alive, or were unfit to give evidence to us. In any event, the recollections of the witnesses to events in the 1960s and 1970s may be expected to be better when they gave evidence to the Hughes Inquiry than they would be now. The evidence of witnesses to the Hughes Inquiry was in many cases subjected to vigorous cross examination, and so the transcripts of their evidence provide an extremely valuable source of information on many matters. This is subject to the qualification that a 'cold' transcript cannot completely convey those nuances that may be gleaned from the demeanour of the witness while giving evidence, such as firmness of recollection or uncertainty, evasiveness, or the transparent conviction of a witness trying to do their honest best, to name only some considerations.

5 Although the analogy between this Inquiry and an appeal court sitting in an appeal from a judge conducting a trial without a jury is not an exact one in many respects, our approach to the evidence given to the Hughes Inquiry, and to its factual findings and the conclusions based on those findings as contained in its Report, has been to follow the approach of an appeal court to the findings of a trial judge sitting without a jury. Lord Lowry, then the Lord Chief Justice of Northern Ireland, in giving the decision of the Northern Ireland Court of Appeal in Northern Ireland in the case of *Northern Ireland Railway Company v Tweed* [1982] 15 Northern Ireland Judgement Bulletin at pages 10-11 gave an authoritative exposition of the relevant law and principles.

6 Adapting Lord Lowry's principles to the position of this Inquiry when considering the evidence given to, and the Report of, the Hughes Inquiry we have applied the following principles:

(1) The findings of the Hughes Inquiry on primary facts should rarely be departed from by this Inquiry if there is evidence to support those findings. This principle applies strongly to assessments of credibility, accuracy, powers of observation, memory and general reliability of the witnesses.

(2) This Inquiry is in as good a position as the Hughes Inquiry to draw inferences from documents and from facts which are clear, but even here must give weight to the conclusions of the Hughes Inquiry.

(3) This Inquiry can more readily depart from the findings of fact and conclusions of the Hughes Report if the Hughes Inquiry misunderstood or misused the facts, and may thereby have reached a wrong conclusion.

(4) This Inquiry should not resort to conjecture or to its own estimate of the probabilities of a balanced situation as a means of rejecting the conclusions of the Hughes Inquiry on a disputed matter.

Ages of residents in Kincora

7 Kincora Boys' Hostel was opened by Belfast Welfare Authority on 6 May 1958, and until it finally closed in October 1980, 370 young people resided in Kincora.[1] As the name 'hostel' implied, Kincora was not a children's home. As a report of 28 February 1958 by the Belfast City Welfare Officer explained, it was intended from the outset to be:

> "a hostel used to provide accommodation for boys over school age and particularly those who it has not been possible to Board out [that is to foster] i.e. those who may have a parent who wishes to visit, and any that are difficult socially".

8 It was recognised from the outset that whilst the boys would normally pass out of care when they reached the age of eighteen:

> "It may be necessary to permit some to remain in the hostel until they are 21. In those circumstances, the necessary approval will be sought from the Ministry of Home Affairs".[2]

This reflected the requirements of S. 96 of the Children and Young Persons Act (Northern Ireland) 1950, and its successor, S.121 of the Children and Young Persons Act (Northern Ireland) 1968. That Kincora was a hostel for boys and not a children's home was, as Mr Bunting pointed out when he gave evidence to this Inquiry, emphasised by the title of "warden" given to the officer in charge, something that was, "more like a youth hostel term". [3]

9 The school leaving age was fifteen in 1958, and was raised to sixteen in 1973. This meant that between 1958 and April 1973 the hostel was intended for boys who were over fifteen and under 21, and from 1973 to 1980 between the ages of sixteen and 21. However, as the City

1 KIN 1086.
2 KIN 1129.
3 Day 218, pp.87 and 88.

Welfare Officer explained in 1958, "boys would normally pass out of care on reaching the age of eighteen years"; in practice the older males in Kincora at any given time were up to eighteen years old. Therefore the position was anticipated as being that between 1958 and 1973 the residents would be between fifteen and eighteen years of age, and from 1973 to 1980 between sixteen and eighteen years of age. However, it was frequently the case that boys under school age were resident in Kincora, sometimes for lengthy periods.

10 As part of its closing submissions after the completion of the public hearings into Kincora the HSCB carried out an analysis of the Kincora admissions register.[4] The HSCB concluded that between 1958 and 1973:

> "The vast majority of admissions were for boys over fifteen, which was the relevant age for compulsory school age at that time. Admission of boys under fifteen were, in the main, of a short-term nature with long-term admissions of boys aged under fifteen relating to those that [were] aged fourteen years six months or older". (Emphasis added)[5]

Dealing with the position after the raising of the compulsory school age to sixteen in April 1973 the HSCB observed that:

> "The change seen, however, is that the majority of admissions to the Hostel were now made up of admissions of boys aged under compulsory school age".[6]

11 Although these statements are correct as far as they go, in our view they do not address the reality that throughout its existence an unacceptable number of boys were resident in Kincora when they were too young and were there for too long. This can be demonstrated by the histories of four boys under fifteen who were admitted between 1960 and 1967 considered at 4.12 of the HSCB submissions. For example, HIA 199 was only fourteen and two months when admitted to Kincora in February 1960. He remained there for fifteen and a half months until June 1961, so for ten months of that period he was well under the minimum age at which he should have been admitted. HIA 199 was subsequently readmitted on other occasions. Others were also admitted who were

4 KIN 143205-143216.
5 KIN 143149.
6 KIN 143151.

aged up to fourteen and four months of age, and whose subsequent stays until they passed the age of fifteen ranged from six months in the case of KIN 24, to eight months in the cases of KIN 136 and KIN 127, and ten months in the case of KIN 2.

12 There were also a significant number of children who were well under the age of fifteen when they were admitted, even though they were only admitted for a few nights.[7] For example one child aged thirteen and two months was admitted for three nights, and in September 1968 a boy aged ten and eleven months was admitted with his brother aged nine and ten months for six nights whilst their mother was in hospital.[8] In 1975, of a total of twelve boys admitted that year, six were under sixteen. Three of the six were brothers, two of whom were aged nine, and the third was aged ten and ten months. These three boys were in Kincora for eleven nights before being discharged to Corrymeela.[9] This pattern continued. In 1977, out of thirteen admissions, eleven were under sixteen, including three brothers aged eleven, twelve and thirteen and a half.[10] In 1978, of twelve admissions, seven were under sixteen, and of those, three were under fifteen; one of the three was only fourteen and three months on the date of his admission.[11] In 1979 six out of eight admissions were under sixteen and one who was fourteen and three months remained in Kincora for almost three months.[12] The last boy to be admitted to the home was thirteen and five months old when he was admitted in January 1980.

13 Whilst many of those were just under "the cusp" of fifteen, or sixteen when the school leaving age was raised, throughout Kincora's existence there was a consistent pattern of the admission of young boys who were well under school leaving age, even if in many cases those boys only spent a few nights in Kincora. Whilst the onset of severe civil unrest, and subsequent community violence and terrorism after October 1968 undoubtedly placed severe strains on social services, the practice of placing young boys in Kincora pre-dated 1968 and was to become more pronounced in the late 1970s. Whilst the intention was that this was something to be avoided if at all possible, and only resorted to in the

7 KIN 143209.
8 KIN 143210.
9 KIN 143213.
10 KIN 143214.
11 KIN 143215.
12 KIN 14216.

most exceptional circumstances, in practice that was ignored on many occasions. In our opinion that should not have happened as frequently as it did, and the absence of contemporary comment, or steps being taken to prevent it happening, suggest that in practice it was accepted as a necessary evil.

14 As the HSCB recognised, the facilities at Kincora were not designed for young children. Mr Bunting, who was Children's Officer in the Belfast Welfare Authority, accepted when he gave evidence on Day 218 that children's officers would have been aware that younger children had to be accommodated in the hostels, usually in an emergency and on a short-stay basis because of the inadequacy of the residential provision, particularly for Protestant children during the 1950s and the 1960s. He also made the point that there was an increased demand for residential care in the EHSSB area, which extended into the 1980s.[13]

15 Whist we recognise that it would not have been possible to completely avoid placing young boys in Kincora in emergencies for very short periods of time, this should always have been regarded as something that should never have lasted for more than two or three days at most, because Kincora was not a children's home. It had no recreational activities for young children other than watching television; the staff were not trained or experienced in looking after young children; and, most important of all, this was an environment for young men who were working and approaching manhood. It was therefore a completely unsuitable environment for young children, with the risk of bullying and introducing younger boys to undesirable habits such as drinking and smoking, not to mention the risks of peer sexual abuse that we have referred to in the previous chapter.

16 In later years it also seems to have been the position that a practice developed of placing boys in Kincora who were disturbed and could not be placed elsewhere, such as Richard Kerr whose accounts of life in Kincora we considered in the previous chapter. There were clearly no grounds for moving boys presenting difficult behaviour in other homes to Kincora because of better staffing levels or better trained staff, and it is possible that social workers felt that the boys' patterns of behaviour were more suited to an older peer group, where the other residents would be more capable of coping with the situation than the younger

13 Day 218, pp. 88 and 89.

children in the other homes. On occasions, children were placed there because more suitable accommodation was unavailable, as when places at the Palmerston Assessment Centre were unavailable. Whilst some of these problems may have been exacerbated by the dramatic increase in demand due to the civil unrest in Belfast and surrounding areas, that the problems persisted led us to conclude that **there was a systemic failing because of a lack of a strategic, co-ordinated overview of the problem.**

Staffing numbers and accommodation

17 It is axiomatic that a hostel or children's home must have sufficient staff to enable it to meet the requirements of the institution. The issues of the number of staff, and the quality of staff, are interrelated to a considerable degree, but before we consider these complex matters, it is necessary to examine what was contained in the concept of the Kincora Hostel for Working Boys, and the term working boys includes those who were trying to get work.

18 Although the number of boys in Kincora fluctuated slightly, with as many as thirteen in the hostel in October 1964,[14] until the use of attic accommodation was discontinued the hostel normally accommodated eleven residents, and this was reduced to nine once the attic was taken out of use. The building is a Victorian, detached structure with two floors and an attic; the attic being reached by a narrow, steep, staircase from the first floor landing. The attic contained two rooms which seem to have been used as sleeping accommodation in the early years of the hostel. When the hostel was opened, a contemporary newspaper report said that it had accommodation for nine residents, the sitting room for general use, and an additional reading and study room.[15] A sketch of the floor plan for each part of the building which seems to have been prepared during the Caskey Phase One investigation in 1980 shows that by that time there were three rooms on the first floor each described as a 'dormitory', one bedroom, two bathrooms and a toilet. On the ground floor there was a third bathroom and a second toilet, and a fourth bedroom. At the front of the house there was an office, a kitchen, a dining room and another large room which, together with the dining room, opened off the hall and faced the Upper Newtownards

14 KIN 140533.
15 KIN 1118.

Road. In 1967 a single-storey extension had been added at the rear of the building containing a bedroom and an office. The bedroom was occupied by Mains, but until the extension was built Mains occupied a room on the first floor where he shared the toilet and washing facilities with the boys.

19 As well as being responsible for the control and management of the hostel, attending to the general welfare of the boys living in the hostel, and carrying out any other duties required of him from time to time, the warden had four other specific duties contained in the conditions of appointment which are worthy of mention:

> "(c) To make contacts with reputable industrial firms, which afford opportunities for apprenticeships.
>
> (d) To encourage the boys to have savings accounts.
>
> (e) To encourage the boys to attend evening classes pertaining to their trade.
>
> (f) To encourage the boys to develop any handy craft abilities in their leisure time".[16]

20 The conditions of appointment stipulated that remuneration included full board, lodging and laundry free of charge, with an entitlement to 21 days annual leave (including statutory holidays). In particular they stated that:

> "The position is a full time one and the person appointed shall devote his entire time to the duties of the office. The hours of duty will be a 96 hour fortnight (exclusive of meal times)."

Given that the only other member of staff for the first four years of Kincora's existence was a cook, this meant that in practical terms Mains could never have any time off. It seems that, apart from a period of approximately six weeks in September of 1958 when he was ill,[17] or was absent in December 1960 for two weeks when he was on annual leave and when a gardener/handyman was seconded to cover his duties,[18] he was on duty all the time.

16 KIN 1146 and 1147.
17 KIN 140016.
18 KIN 140318.

21 It was not until March 1962 that a second member of the care staff was appointed as assistant warden, but he only remained in post until late October that year. A replacement was not secured until July 1963, and he only remained in post until the end of May 1964. Semple was then appointed as assistant warden and served in that capacity from September 1964 until he resigned in February 1966. Some assistance was given between May and September 1966 for up to twenty hours a week. It was not until Semple was re-appointed as assistant warden in June 1969 that the post was filled, having been unsuccessfully advertised on five occasions in 1968.

22 The lengthy periods when there was no assistant warden to help Mains resulted in the Welfare Committee being given permission by the Ministry of Home Affairs to make two payments, one of £100 in July 1968 and one of £125 in May 1969, in recognition of the, "additional responsibility and hours worked", and his inability to take leave, "owing to the post of assistant warden being vacant the greater part of the last few years". Given that for the first period of 1968 the Welfare Authority did not have to pay £825 in salary for the vacant post, an honorarium of £100 was hardly generous when:

> "He has had to be available on duty each day [i.e. 7 days a week every week] for the whole of twenty months. Consequently, he has not only been working under a considerable strain, but has had to give service considerably in excess off what would normally be expected".[19]

23 In 1971 it was recognised that the complement of two care staff was insufficient, and McGrath took up employment at Kincora as a house-father. Thereafter the care staff complement remained with Mains as the officer in charge, with Semple as his assistant, and McGrath as a house-father until all three were suspended on 4 March 1980.

24 In addition to the cook who was continuously employed at Kincora throughout its existence, a second domestic member of staff was added in November 1966, and she remained in post until the hostel closed. She initially worked from 7.00am until 12.30pm, although her hours were reduced to 8.00am to 12 noon after McGrath was appointed. Some two years later she reverted to her previous hours, and resumed the practice of waking the boys as she had done before, in addition to her main cleaning and laundry duties.[20]

19 KIN 1158.
20 KIN 143157.

25 In its written submission the HSCB accepted that the staffing establishment in Kincora between March 1958 and December 1961, "was unacceptably low".[21] It recognised that, as Fionnula McAndrew said:

> "there were enormous challenges in terms of recruiting and getting staff for the hostel. Clearly it is not a satisfactory position that you have somebody who is working alone with a group of boys..."[22]

26 The whole issue of staffing numbers in homes and hostels is complex, but in our view there were serious deficiencies in the care staff complement at Kincora throughout its existence, and not just between March 1958 and December 1961. If Kincora was intended to provide accommodation akin to someone being in lodgings, making their own meals and doing their own laundry, with a staff member present to support after-care, then appointing only one member of staff as warden would be understandable. Such a person would not be expected to remain on the premises all the time, and the boys would essentially be living independently.

27 As we have already seen, the warden was expected to be on duty for long hours, and to perform various administrative and other tasks such as helping the boys to find work, tasks that cumulatively required a considerable period of time. In addition (a) a significant proportion of the boys at various times were of school age, (b) some were moved there because children's home staff could not cope with them, (c) they were in dormitories, rather than having independent flats, (d) they were provided with pocket money, food and laundry, such that Kincora was essentially run as if it was a children's home, and (e) it was run in accordance with the Children's Home Regulations.

28 From the very beginning Kincora represented a hybrid model of institution, and as such it needed a higher level of staffing from the start. In England the Castle Priory Report in 1969 gave worked examples for a 12-bed working boys' or girls' hostel, and suggested two levels of staffing, depending on whether a ratio of one member of staff to every five residents was applied, or one to six. They also provided examples for both a 40-hour working week and a 45-hour week. We have applied the more generous 40-hour week and the less generous ratio of 1:6 to the circumstances of Kincora.

21 KIN 143158.
22 Day 215, p.161.

29 In our view, for Kincora with nine beds and staff working a 40-hour week, the necessary staffing applying the Castle Priory recommendations would amount to the following:

Head and deputy	1.50 posts providing 60 hours per week
Day time weekday office cover	0.75 post providing 30 hours per week
Weekend care cover 2 days x 18 hours x 1.5 staff)	1.35 posts providing 54 hours per week
Weekday care cover 5 days x 12 hours x 1.5 staff)	2.25 posts providing 90 hours per week
Holiday Relief	0.40 post providing 16 hours per week
Total	6.25 posts providing 250 hours per week

We consider these figures to be reasonable, especially if they were offset by reducing some of the domestic hours.

30 Our view is that the staffing level when Kincora was opened in 1958 was grossly inadequate, and the appointment of a deputy warden in March 1962, although welcome, meant that the staffing level was still woefully insufficient. When McGrath was appointed as a house-father in 1971, the staffing cover became more realistic, but still fell short of the level required. Had the Castle Priory recommendations been applied, the establishment required was 6.25 full-time equivalents, which might have been offset by some reduction in ancillary staff. The significance of the inadequate number of staff was that it placed undue stress on individual members of staff, and created a set of circumstances that permitted those who wished to abuse boys to work for long periods as the sole member of staff on duty without the likelihood that they would be observed or disturbed.

31 In arriving at these conclusions we have not overlooked that Bob Bunting said that Castle Priory recommendations for a Group 3 home were met, however, as Kincora was re-graded to Group 2 and it was a hostel, rather than a home, its staffing did not meet Castle Priory levels. It appears that the DHSS issued staffing guidelines in April 1974 to the effect that one member of staff was required for every 3.5 young people in a hostel.[23] This would only have resulted in a staffing establishment of 2.6 staff, but assuming that Kincora was serving nine young people at this time, and the numbers at times exceeded that, this was still inadequate

23 KIN 199.

because it was lower than the Castle Priory standards. Irrespective of the Castle Priory recommendations we consider that there should have been at least three care staff provided for at Kincora from its inception. **The failure to provide adequate care staff represented a systemic failing.**

32 The result of the wholly inadequate staffing was that Mains worked for very long periods of time without any relief. Indeed on one occasion he was reprimanded for not being on duty on one day. Working at that pressure and without the opportunity for rest and recreation increases the risk of inappropriate behaviour on the part of staff, such as excessive drinking and seeking emotional or sexual solace from the boys. Even when the complement did increase to three, we consider that it was still inadequate. The way it was operated in practice meant that often there was only one adult male in the building at a time, and this meant that the opportunity for abuse was greatly increased. As the evidence of the residents we examined in the previous chapter showed, this was something that McGrath was able to exploit in his abuse of the boys in Kincora.

PART TWO

Qualifications of care staff

33 Semple and McGrath did not have any formal childcare experience or training when they were appointed to their posts of assistant warden and house-father in 1964 and 1971 respectively. This was commonly, indeed predominantly, the case throughout the United Kingdom in the 1960s. Although the standards of professionalism were improving, particularly in the late 1960s and early 1970s, as late as the early 1970s it was still often the case that care staff such as house parents lacked any formal qualifications or previous experience when they were appointed. The hours for such staff were very long and the remuneration low, and as a result there was a high turnover of staff. Social workers who had, or acquired, professional qualifications often left residential childcare for field social work where the hours were shorter and remuneration better. We have referred to many such examples of unqualified staff in other institutions we have examined elsewhere in our Report, and it was only as a result of the recommendations of the Hughes Report that the overall level of qualified staff in Northern Ireland was improved. This meant that where there had

been fewer professionally qualified staff in residential childcare in Northern Ireland before the 1980s than the rest of the United Kingdom, after the Hughes Report the proportion of professional staff in residential childcare in Northern Ireland became higher than elsewhere in the United Kingdom.

Joseph Mains

34 When Mains applied for the position of warden in 1958 the conditions of employment required candidates to have:

> "Suitable working knowledge of the running of a children's home and preference will be given to a person having had experience in the care of boys in the age group 14-21 years".[24]

Of the four candidates for the post, two did not meet that criterion,[25] whereas Mains and the remaining candidate did. Mains was 28 and had been a male nurse at Purdysburn Hospital for seven years before he was appointed resident warden at Park Lodge Boys' Home for fourteen months until February 1957. When Park Lodge closed, Mains was transferred to work in an old people's home, and worked there for a further nine months until appointed warden of Kincora.[26] The Hughes Inquiry found nothing in his background that might have alerted either the Belfast Welfare Authority or the MoHA to possible homosexual tendencies on his part at that time. A MoHA inspector who knew him from his previous childcare work was complimentary in recommending his appointment to the Ministry. We do not consider that the decision to appoint Mains as warden can be criticised.

Raymond Semple

35 Semple applied for the post of resident assistant warden at Kincora when it became vacant in 1964. He was 42 and had worked as a store-man in the Harland and Wolff shipyard for seventeen years. He had no childcare experience, but had been an officer in the St John's Ambulance Brigade for fifteen years with Mains. Mains provided Semple with one of his two references, saying that he had:

> "Found [Semple] to be a man of good character, honest, reliable and indeed very keen on all aspects of youth work".

24 KIN 1146.
25 KIN 1145.
26 KIN 1140.

As the Hughes Inquiry said in its Report at 3.16[27] in retrospect:

> "It may just be possible to feel some uneasiness in the fact that Mr Mains and Mr Semple were single, were known to each other and that Mains acted as referee for Mr Semple in his application for a post involving the care of teenage boys."

We considered it poor practice that the recruitment processes were such that it was acceptable for Mr Mains to provide a reference for an applicant for a post for which he was the line manager. Nevertheless, we agree with the Hughes Inquiry when it said that it would not be realistic to suppose that these matters were suggestive of a pattern of homosexuality on the part of Mains and Semple in 1964. To do so would be acting with the advantage of hindsight, as would saying that because both were unmarried males working in a boys home, those facts alone should have raised a suspicion that both were, or might be, capable of sexually abusing boys in their care.

36 We now know that Mains pressured Semple into resigning as assistant warden in February 1966 because he knew of Semple's homosexual behaviour with R 1. That knowledge was not revealed by Mains to his superiors, who therefore had no reason to doubt the explanation Semple gave in his letter of resignation in 1966 that he had applied for a better-paid job which would enable him to assist his family more.[28] When he applied again for the post of assistant warden in May 1969, Semple explained in his application form that his elderly mother was not in good health at the time he resigned and was living alone.[29] When Semple was reappointed assistant warden in 1969, although he did not have a childcare qualification, he had working knowledge of the childcare requirements of the post from his previous experience working in Kincora. In his earlier employment he had also attended a two-week residential refresher course in Manchester University in 1967 on the emotional problems of adolescent boys.[30]

37 Mains concealed his knowledge of Semple's homosexual behaviour with boys in Kincora, and, at this time there were no known contemporary allegations against Semple. To all appearances he had been a satisfactory employee in the past, and he had shown his commitment to Kincora by doing some voluntary work there during the six months before his application in 1969.

27 KIN 75219.
28 KIN 1190.
29 KIN 1195.
30 KIN 1192.

38 By this time the Belfast Welfare Authority had been attempting to fill the assistant warden's position since January 1968. The post had been publicly advertised five times before a candidate was appointed, but the successful candidate failed to take up the post. As can be seen from a memorandum of 4 April 1969 giving brief details of the nineteen candidates considered in 1968, even after the salary was increased it was extremely difficult to attract suitable staff who were prepared to live in when required.[31] It is not unreasonable to infer that when Semple reapplied in 1969, and there was no apparent reason why he should not be reappointed, the Belfast Welfare Authority was relieved to find someone who they had reason to believe had been a suitable person in the past who was willing to take the job. In those circumstances, like the Hughes Inquiry, we consider there is no basis upon which to criticise the Belfast Welfare Authority for re-employing Semple in 1969.

The Appointment of William McGrath in 1971

39 In 1971 it was decided to augment the care staff at Kincora by appointing a house-father to assist the warden and the assistant warden. Unlike them the house-father was not required to do sleeping-in duties. At that time McGrath was working as a clerk in a firm of estate agents at a salary of £600 a year.[32] The House Parent Grade II position had a salary scale starting at £663, rising to £867 per annum, together with a further £219 per annum in place of "emoluments", (that is full board, lodging, light, fuel and laundry all provided free of charge),[33] although in due course the MoHA only approved his appointment at what was described as the "minimum point of MJC Asst House Parent Grade I scale".[34]

40 At that time McGrath was 54, married with three teenage children,[35] and the prospect of a significant increase in his income, together with the security which the position would involve, must have been very attractive to him. This would be particularly the case given the financial difficulties he was in following the dispute with Roy Garland to which we refer later. McGrath had no relevant qualifications or experience, but had favourable references from two ministers of religion, although, as

31 KIN 1175.
32 KIN 1209.
33 KIN 1215.
34 KIN 1221.
35 KIN 1209.

the Hughes Inquiry observed, those references were of limited value in determining his suitability for work in residential childcare.[36] As with Mains and Semple, there was nothing in his background that could have alerted the Belfast Welfare Authority to McGrath's predilection for homosexual abuse of adolescent boys.

41 We therefore agree with the Hughes Inquiry that at the time all three appointments were made, there was nothing to alert either the Belfast Welfare Authority as the prospective employer, or the MoHA whose approval was required for such appointments, to their homosexual and sexually abusive tendencies. Whilst we agree that it is regrettable that none had any formal childcare qualifications, and only Mains had any previous relevant childcare experience, as we have already pointed out these deficiencies were typical of many who worked in residential childcare at that time in Northern Ireland and in Great Britain. Pay levels for residential child care workers at this time were very low. Pay was negotiated nationally and there would have been limited discretion for welfare authorities in applying the national rates. The authority had attempted to improve the pay of Kincora staff by regrading the home, but the rates of pay would still have been lower than those of care staff in training schools. Yet the demands on Kincora staff were very similar to those of training school staff. There would have been some discretion in appointing staff higher on the incremental scales, but it may have been policy always to appoint on the lowest increment, as was the case with McGrath. It is hardly surprising, therefore, that there were difficulties recruiting staff to Kincora. We do not consider that the appointments of Mains, Semple and McGrath to their respective positions at Kincora involved any systemic failings on the part of either the Belfast Welfare Authority or the MoHA. However, later in this chapter we will consider the question of how it was that three homosexual abusers of young males came to occupy all three care staff positions in Kincora.

The Effectiveness of Kincora as a boys' hostel

42 We have already drawn attention to the requirement that the warden helped boys to find apprenticeships. It was clear that this was an important part of Mains's duties as warden, and one which the evidence before us

36 KIN 75220.

suggests he took seriously. HIA 199, who was in Kincora between 1961 and 1963, appreciated that the purpose of Kincora "was to get us into the work environment...It was to ready you for what was ahead".[37] Mains seems to have gone to some lengths to find jobs for boys in Kincora to judge by the records he kept for HIA 199, although that may have been influenced to some extent at least by his sexual relationship with HIA 199 at that time. However, Dr Hilary Harrison, then Hilary Reid, was a frequent visitor to Kincora as a young and newly qualified social worker in the 1970s. She considered that this was a task that Mains performed very well. Her evidence was that some of these boys "were not the easiest to place in employment, Mains probably had more employment networks than social workers at the time".[38]

43 Dr Harrison's description of Kincora during Mains's stewardship was:

> "that it was a very efficiently run home with an officer in charge or superintendent who gave the impression of being extremely competent. He was very good at communicating with social workers in relation to what was happening with the boys in his care".

Despite Mains's lack of professional training, she described Mains as "extremely competent".[39]

Preparation for life after care

44 By the 1970s it was becoming apparent that Kincora, like many other residential institutions for children and young people, was not preparing them for independent living, with the result that when the children left the home, or the hostel in the case of Kincora, they were ill-equipped for the challenges brought by independent living. This was, in part at least, because they were being fed, their laundry was being done for them, and they did little, if anything, to help with household cleaning duties. This led the Social Work Advisory Group (SWAG) inspector to report on his visit in August 1979 that he doubted that there was any systematic instruction in Kincora of independent living skills and how to acquire a general capacity to cope with issues in daily living. He observed that, "If all or nearly all the domestic and social needs of the adolescent are being met by the adults around him, he is actually being taught to be dependent".[40]

37 Day 209, p.71.
38 Day 223, pp.90 to 91.
39 Day 223, p.92.
40 KIN 1136.

45 We consider it was another significant flaw in the way Kincora actually functioned that such a criticism could justifiably be made after the home had been functioning for more than twenty years. We have already described Kincora as a "hybrid" between a children's home and a hostel. In our opinion one of the reflections of that "hybrid" institution was inadequate preparation of the boys for independent living when the time came to leave the hostel for those who were not going to return home but who would live elsewhere, **something we regard as a systemic failing.**

Systemic failings to date

46 In those matters we have so far considered we find that **there were the following systemic failings in the way Kincora operated:**

(1) Too many children were admitted into Kincora who were too young to be placed in such an environment.

(2) Too many of these children spent too long in an unsuitable environment when they were admitted.

(3) There were insufficient care staff throughout its entire existence, and in particular to deal with the younger children who were placed in Kincora from time to time.

(4) The way the adolescents were looked after in Kincora created an attitude of dependence, exacerbated by inadequate preparation for independent living after they left Kincora.

(5) Inadequate pay and poor terms and conditions of employment for care staff.

PART THREE

Monitoring and inspections 1958 to 1973

47 In this part of the chapter we first of all examine the extent to which the hostel was monitored and inspected. There were several ways in which the day-to-day running of Kincora, and the welfare of the boys resident there, could be supervised. These were considered by the Hughes Inquiry during two periods, the first being from 1960 to 1973, and the second being from 1973 onwards, when the EHSSB took over responsibility for Kincora on the reorganisation of local government. The Hughes Inquiry dealt with these in some detail from 3.23 of their Report onwards, and

as we are in general agreement with their comments it is unnecessary for us to cover the same ground in the same amount of detail.

48 The first level of monitoring was through the monthly visits to the hostel required by Regulation 5 (2) of the Children and Young Persons (Welfare Authorities Homes) Regulations (Northern Ireland) 1952 (The 1952 Welfare Authorities Homes Regulations). This required the Children's Officer to visit the hostel once a month. The Hughes Inquiry found that from 1960 to 1962, when Miss Brown was the Children's Officer, only about 50% of the required reports were minuted. In February 1963 the monitoring visits were delegated to Mrs Wilson, the Homes Officer, who completed the visits except for minor omissions until September 1965 when responsibility reverted to Miss Brown. From September 1965 to the end of 1967 the visits were undertaken with occasional omissions by either Miss Brown or her assistant Mr Moore. Mrs Wilson resumed the visits from January 1968 on her appointment as Assistant Children's Officer. The Hughes Inquiry found that Mrs Wilson's records from January 1968 to September 1973, when the Belfast Welfare Authority ceased to exist, demonstrated almost full compliance with the statutory requirements except for very occasional gaps during the summer holiday periods.[41]

49 The next level of monitoring was provided by the monthly visits made by a member of either the Welfare Committee or of the Children's sub-committee of the Welfare Committee. These visits were required by Regulation 5 (1) of the 1952 Welfare Authorities Homes Regulations. The Hughes Inquiry found that whilst this requirement was largely met between 1960 and 1965, the frequency of visits declined thereafter, with several three-month breaks in 1967 and 1968. In 1971 the pattern again deteriorated, and between January 1972 and September 1973 only two visits were minuted. Whilst it may be that some visits were not recorded, nevertheless we are satisfied that there were many occasions when, as the Hughes Inquiry put it at 3.37, "it is nonetheless unsatisfactory that the Committee should have substantially neglected its statutory duty in this respect".[42]

50 The Hughes Inquiry only found records of two inspections by the Ministry of Home Affairs between 1960 and 1973, and these were carried out in

41 KIN 75221.
42 KIN 75223.

1965 and in 1972. However, the Kincora record book showed that there were twelve other occasions when MoHA inspectors visited. However, it is likely that these other visits involved less formal contacts between the MoHA inspectors and the hostel staff.[43] The Hughes Inquiry was unequivocal on this level of frequency of inspections, saying, "we do not believe that there can be any defence of the Ministry's record of formal inspections of Kincora", and that two inspections between 1960 and 1973, "was insufficient to discharge central government's responsibilities for ensuring the well-being of the children". We agree, and **we consider this was a systemic failing.**

51 The period following the reorganisation of local government in 1973 until 1980 was more satisfactory in some respects. The post of Children's Officer no longer existed after 1973, and from 1 December 1975 a Direction was given by the DHSS which required a social worker to visit homes and hostels at least once a month. In the EHSSB the task had already been delegated to members of the R&DC (Residential and Day Care) management team from October 1973. The Hughes Inquiry examined the EHSSB records and found that the monthly inspections were carried out in full from October 1973 until late 1979, although the requirement to "sign in" to show that an inspection had taken place was only very occasional after the retirement of Mrs Wilson in July 1975. The reports themselves were often short and stereotyped.

52 In addition, all homes and hostels, including Kincora, were required to submit a weekly report to the District Management. The Hughes Inquiry found that observance of these administrative requirements was good.

53 The final layer of inspection was provided by the monthly visiting and reporting requirements inherited from the 1952 Welfare Authorities Homes Regulations. From December 1975 these visits were placed on a quarterly basis by the 1975 Direction from the DHSS to which we have already referred. These visits were performed by members of the Personal and Social Services Committee (PSSC) of the EHSSB. From the third quarter of 1977, the Hughes Inquiry found at 4.13 that the pattern of quarterly visits was; "of less than full compliance of the statutory requirements", but concluded at 4.14 that, "visiting was regarded as more than a purely formal exercise".[44]

43 KIN 75224.
44 KIN 75254.

The 1979 SWAG Report

54 As we already mentioned, the first inspection after the 1973 reorganisation of local government by the DHSS came with a SWAG Report following an inspection on 20 June 1979. The Department of Health (which replaced the DHSSPS during the course of our Inquiry) advanced a hypothesis through Dr Harrison that this was the result of the change in emphasis towards advising those responsible for homes or hostels, rather than inspecting them. In its closing submissions on the Kincora module the DoH adopted its submissions regarding Bawnmore where it said:

> "that [the DoH] feels the Hughes Inquiry did not have the benefit of a clear exposition from the witnesses [that] the Seebohm Report played in the apparent change of practice post the 1973 reorganisation of social services".

It went on to submit that:

> "the retraction of inspection activity was not a gradual lapse into complacency, but a change of focus to supportive and advisory relationships with social care providers and an emphasis on visits rather than regimented inspections".[45]

55 We explain elsewhere in this Report why we do not accept this general proposition. In the context of inspections of Kincora, it is sufficient to point out that this hypothesis is completely at variance with what the Hughes Inquiry recorded in its Report at 4.17 as being the case. We consider it appropriate to set out the relevant paragraph in full:

> "In February 1976 SWAG also introduced a policy objective of annual inspection of all day care and residential facilities for children and young persons. Mr Patrick Armstrong, then Deputy Chief Social Work Advisor and from August 1983 the Department's Chief Social Work Advisor, gave evidence that it had not been possible in practice to meet this objective. This was partly because it took a year to recruit a suitable replacement for a Social Work Advisor who had retired in December 1976 and partly because the newly-recruited officer had to go through a period of induction before taking up the full range of duties, including the inspection of children's homes and hostels. Mr Armstrong also stated that SWAG tended to devote more attention

45 KIN 143105.

to voluntary homes than to statutory homes because it was felt that voluntary organisations, with exceptions such as Barnardo's, did not have such well defined structures for the administration and management of homes and that they needed more professional attention. In connection with the introduction of the annual inspection policy from February 1976 an additional Social Work Advisor was allocated to childcare from August 1975, bringing SWAG's childcare complement to three Social Work Advisors. This complement was maintained until 1980 except for the period December 1976 to December 1977 when the retirement referred to above reduced the complement to two".

56 At 4.18 the Hughes Inquiry reinforced this conclusion:

"The Department's evidence satisfied us that the low frequency of inspections arose more from constraints of professional resources than from inspections being given a deliberately low priority by the Social Work Advisors. Given these constraints, the annual inspection target introduced in February 1976 could not be achieved. It is regrettable that the Department did not establish accurately the resource implications of annual inspections before adopting such a policy objective. Nor did it react to its own subsequent experience, which demonstrated clearly that the objective was not being met, either by adjusting SWAG's priorities or increasing its resources."

57 As the evidence given to the Hughes Inquiry on behalf of the Department was given by the Chief Social Work Advisor at the time, someone who had previously been the Deputy Chief Social Work Advisor, in our view the implication 30 years after the event that, "the backdrop of the policy content [had not] been properly explored", in Mr Armstrong's evidence is unsustainable. Had the Seebohm Report provided an explanation when Mr Armstrong gave evidence we are sure he would have relied upon it. We explain in Chapter Two why we did not accept the **Department's argument, and we consider that the Department's failure to maintain an adequate inspection regime, and the same failure by its predecessor the MoHA, were systemic failings on the part of both.**

The effect of the failures to properly inspect Kincora

58 Whilst we regard the failure of Belfast Welfare Authority and the EHSSB to have regular monthly inspections, and the failure of the MoHA and then SWAG to have regular inspections, as systems failures by each of

these bodies, the most important question is whether these failures caused, or at least contributed to, a continuing failure to detect the sexual abuse of residents that was taking place in Kincora. We accept, as did the Hughes Inquiry, that while more regular and perceptive inspections might have helped the children to establish a sufficient relationship of trust with visitors to encourage the children to confide in persons of authority that they were being abused, that cannot be assumed for a number of reasons. First of all, their experiences were seen by the boys as shameful and that made it very hard for them to confide in anyone. Secondly, to disclose what happened meant doing so to individuals such as councillors or inspectors who the boys regarded as remote and unsympathetic. Thirdly, many assumed that if they did complain they would not be believed. Tragically that perception was entirely justified by the repeated failures to take complaints seriously that we will consider later in this chapter. Finally, as confirmed by the evidence of sexual abuse in other institutions we have examined, and the evidence relating to the sexual abuse in Kincora, conduct of that sort is invariably carried out in secret and is extremely hard to detect until a child has the courage to complain to someone who takes what they have to say very seriously.

59 It is noteworthy that despite Mrs Wilson having been known to, and liked by, a number of Kincora residents who had been in her care when she had previously been matron of the Brefne Children's Home, no-one felt sufficiently emboldened to complain to her of abuse. By the same token, neither of the domestic staff, nor many boys who were resident in Kincora but who were not abused, realised what was happening. There were no obvious signs of tension or unhappiness evident to visitors or inspectors. For example, Dr Hilary Harrison recalled how when the allegations surfaced a former resident whose social worker she had been rang her from England to say that he was completely amazed that this could have happened, something he repeated when he returned later to Northern Ireland and discussed this with her.[46]

60 We have therefore concluded that although there were a number of systemic failings by the Belfast Welfare Authority, by the EHSSB, by the members of the Welfare Committee and by the DHSS in failing to properly supervise and inspect Kincora throughout its existence, we cannot say that if these failures had not occurred that would have prevented any further sexual abuse taking place.

46 Day 223, p.87.

61 Before turning to consider the sexual abuse that did occur, we must observe that the outward appearance of Kincora in general was that the material standards in the hostel were high, and that Mains was in other respects an effective, hard working, conscientious officer in charge, properly discharging his duties to the adolescent boys under his care. However, as is now known, he abused the trust placed in him by his superiors in order to abuse some of those in his care, and certainly in the case of Semple turned a blind eye to the risks to boys created by other staff.

PART FOUR

Investigation of complaints of abuse by Social Services

62 In this section we examine a number of occasions when the Belfast Welfare Authority and the EHSSB investigated complaints or rumours of sexually inappropriate behaviour towards Kincora residents by staff. There were at least fourteen such occasions (treating two occasions in 1974 involving R 20 as a single episode), and there were two further occasions when Mains did not report matters relating to the behaviour of Semple and McGrath. Almost all of these occasions were considered in great detail by the Hughes Inquiry, and it is therefore unnecessary for us to set out the relevant evidence in similar detail. Our Terms of Reference are different to those of the Hughes Inquiry, and so we have examined those occasions in the context of our Terms of Reference, although in almost every instance our conclusions and those of the Hughes Inquiry are effectively the same. In the following paragraphs we consider each of these fourteen occasions in turn, and, as will become apparent, in respect of almost every aspect of each occasion the HSCB accepts that there were systemic failings on the part of either the Belfast Welfare Authority or the EHSSB.

The 1966 letter written by R 6

63 R 7 told the Hughes Inquiry that in 1966 he and three other residents were suspicious that Mains was having a homosexual relationship with R 4, and that R 6 wrote a letter about this to the College Street headquarters of the Belfast Welfare Authority. R 7 said that he saw R 6 post the letter in the post box on the corner of North Road opposite the hostel. No such letter has ever been traced. As the Hughes Inquiry observed at 3.95 of its Report, given that R 6 was barely literate, "whether this

had a bearing on the letter's actual arrival at its destination, or on what weight attached to it if it did arrive at College Street, is a matter of speculation".[47] The Hughes Inquiry did not suggest that R 7's evidence about the letter being composed or sent was unreliable, and we therefore accept it was written. We agree that whether it arrived, or if it did, what weight was attached to it, can only be a matter of speculation.

The 1967 complaints by R 5 and R 6

64 In the previous chapter we set out the nature of the allegations made by R 5 in the "statement" he wrote when he went to the headquarters of the Belfast Welfare Authority in College Street in early 1967. In this document R 5 made three allegations about Mains. The first was that he had been drinking on a summer camp attended by the Kincora boys, and was getting drunk every Friday and Saturday night when he left the hostel. The second allegation was that he had asked R 5 for a kiss, feeling his body and putting his hands down R 5's underpants while R 5 was washing. The third was that Mains had made a number of approaches to R 6, (a) by coming to his bed and feeling around R 6's body; (b) telling R 6, "you look lovely in the water" when R 6 was taking a bath; (c) calling R 6 for work whilst Mains was only wearing his underpants; and (d) saying, "give me a kiss" to R 6.[48]

65 Robert Moore told the Hughes Inquiry he could not recall taking the statements of R 5 and R 6, but accepted it was quite likely he did. However the boys told the police Mr Ross took the statements. Mr Mason, who had been the City Welfare Officer, and hence the chief officer in the Belfast Welfare Authority, since 1960, interviewed Mains about these allegations on 8 September 1967. Mr Mason recorded the answers Mains gave to each of the allegations in typewritten notes he prepared on 11 September 1967. Mains denied drinking excessively, either at the camp or when he went out from Kincora on Fridays and Saturdays. Mr Mason appeared amused by these allegations, adding that to his knowledge Mains, "was a very light drinker of intoxicating liquor", although he did not explain how he came by that knowledge. This is at least open to the inference that Mr Mason had been present with Mains on social occasions. Mr Mason noted that Mains was uneasy and apprehensive early in the interview but as it progressed became more confident and self assured.

47 KIN 75234.
48 KIN 75236.

66 Mains said that both R 5 and R 6 wore their hair long, and he asked them both for a kiss to get them to cut their hair. He said that he put his hand down R 5's underpants to check that R 5 had changed his underpants because he was inclined not to do so. He said that he washed R 6's long hair because R 6 would not bath himself. He said he checked R 6's clothing in bed because R 6 was one of the worst of those boys who would wear their day clothing (presumably meaning their vest and/or underpants) under their pyjamas. He said he woke R 6 as soon as he (Mains) got up because R 6 was a bad riser, and he might have forgotten to put on a dressing gown. Finally, he said that both R 5 and R 6 had been troublesome, and he had to chastise R 5 the day before R 5 had gone to College Street.

67 Mr Mason concluded that R 5 and R 6 had stated, "facts, most of them agreed by (Mr Mains) to be true, but that they might have tried to put a construction upon them for malicious reasons". He went on to conclude that, "taken as it stands it does not present prima facie indication of wrongful conduct". He then made a number of recommendations to which we shall refer shortly. The Hughes Inquiry accepted that he referred the matter to the then Town Clerk, John Dunlop. Mr Dunlop had retired by the time of the Hughes Inquiry, and it would seem that it was only discovered that he was still alive at a late stage of the Inquiry. He did not give oral evidence, but submitted a written statement saying he had no recollection of the papers.[49]

68 We accept that Mr Mason took these complaints seriously, and they were investigated carefully and thoroughly by him as the chief officer of the Welfare Authority. In our view there were clearly possible sexual overtones when Mains's admissions were taken together. Whilst asking two long-haired boys for a kiss could have been explained as an example of a type of banter common at that time, we do not accept that Mains's explanation for putting his hands down R 5's underpants can be regarded as plausible. At the very least this should have raised a suspicion of a sexual motive on Main's part for behaving in this way, and which was therefore capable of putting the remainder of his admitted actions in a different light. Whilst we accept that Mr Mason's judgement was a genuine one, we consider that he made the wrong assessment of Mains's behaviour. In reaching this conclusion we have given very careful consideration to the views of the Hughes Inquiry

49 KIN 75237.

on these events, and their conclusion at 3.117 of their report that Mains's explanations "were individually plausible", and that they could understand Mr Mason's conclusion that the evidence did not constitute prima facie indication of wrongful conduct.[50] In our view, the evidence did constitute prima facie indication of wrongful conduct on the part of Mains.

69 That is not to say that we consider that the matter should have been referred to the police. Mains was a hitherto reliable employee against whom there were no previous allegations. We cannot exclude the possibility that Mr Mason may have been influenced to some degree by a concern that if Mains was reported to the police, or subjected to disciplinary action, finding a suitable replacement may not have been easy in the light of the difficulty in filling the assistant warden's post, to which we have already referred. On balance, and not without some hesitation, we do not consider that Mr Mason's wrong assessment of the possible significance of Mains admitted conduct, and the consequent failure to consider reporting the matter to the police, amounted to systemic failings. This was a borderline case, and one in respect of which views could legitimately differ when it came to reporting the matter to the police.

70 Mr Mason put the documents relating to this matter into a file which became known as "the Mason file", and we shall refer to it in that way. As we shall see, the contents of the Mason file were to be highly significant on a number of occasions during the 1970s. Mr Mason told the Hughes Inquiry that he gave Mains the benefit of the doubt, and that he sent the file, including his recommendations, to the Town Clerk's department. In his report Mr Mason made three recommendations:

(1) "Mr Moore [should] interview the boys again and explain to them the reason for the incidents;

(2) A closer supervision of Kincora;

(3) A careful sifting of any further information which might come our way".[51]

71 When Mr Mason was asked at the Hughes Inquiry why he directed the careful sifting of information, he said he had a doubt in his mind about Mains's supervision of the boys and how Mains saw his role as a supervisor. He ultimately accepted that to some degree he suspected

50 KIN 75238.
51 KIN 75237.

that Mains was a homosexual, and that was a dangerous possibility as he was in charge of boys.[52] In our view, Mr Mason's decision to give the benefit of the doubt to Mains, and to make his recommendations as he did, should not have been the end of the matter. On any showing, Mains's admitted behaviour was not just unwise, but required formal censure. Whilst we do not consider that such censure should have gone as far as dismissal, at the very least Mains should have been given a formal and strong warning about his actions and his further conduct, coupled with clear instructions as to how he should behave in the future. None of these steps were taken. Mr Mason's warning to Mains that, "all staff in charge of boys have to be extra careful as they were vulnerable to these forms of complaints" did not go far enough.[53]

72 It is clear from the Welfare Committee minutes that we have seen that the Committee closely supervised the operation of its homes and hostels, and we consider that the chairman of the Committee should have been kept informed, although the approval of the chairman for the action taken would not have been necessary. The Committee was the elected body responsible for Kincora, and as such its chairman should have been made aware of these matters even if his approval for the action taken was not necessary.

73 The last of the three recommendations made by Mr Mason, namely that there should be, "a careful sifting of any further information which might come our way", implied that steps should have been taken to ensure that any further allegation, or other relevant information, was placed on the Mason file, so that it could be considered in the light of these allegations and not simply as an isolated matter. To be effective, that required a clear procedure to be put in place for reporting such allegations, not just from Kincora but from other homes and hostels, and in the case of Kincora adding them to the Mason file. Such a procedure should not have been confined solely to Kincora, but should have required all such allegations relating to any staff in any home or hostel run by the Belfast Welfare Authority to be reported by staff to Mr Mason or the current holder of his office so that the complaints could be centrally collated and then considered for appropriate action. No such procedure was put in place.

52 KIN 71589.
53 KIN 75237.

74 **We consider the following amount to systemic failings on the part of the Belfast Welfare Authority and the Town Clerk's department in the way in which they addressed the 1967 complaints.**

(1) Mr Mason should not have decided that Mains's conduct did not constitute prima facie indication of wrongful conduct.

(2) The Town Clerk's department should have given a clear response to Mr Mason's recommendations, and the response should have been properly recorded.

(3) Clear procedures should have been devised and put in place to ensure that any further complaints in relation to Kincora were reported to the City Welfare Officer.

(4) Clear instructions should have been issued in written form to Mr Moore, setting out the steps he was to take, especially to ensure closer supervision of Kincora in the future.

(5) Mains should have been given a strong and formal warning as to his conduct on this occasion, together with explicit instructions as to how he was and was not to behave in future.

Comments said to have been made by KIN 66

75 As we have already explained, KIN 66 was employed as the assistant warden at Kincora for five and a half months in the second half of 1967. KIN 14 was a resident in Kincora at this time, and in his RUC statement of 1980 said that KIN 66 was like a father to him, and he got on very well with KIN 66. In this statement he said that KIN 66 told him to be careful of R 2 or Mains when he was having a bath or a shower, or when he was changing. He incorrectly believed that R 2 worked for the Welfare, and he knew that R 2 stayed in Mains's room at weekends, where there was only a double bed.[54] The RUC were unable to trace KIN 66. If KIN 14's allegation about what KIN 66 said to him were correct then it would seem that in 1967 KIN 66 entertained suspicions about Mains's behaviour, suspicions that he should have passed to his superiors. However, as KIN 66 was never traced, and consequently was never asked whether he did give such a warning, and, if so, what his reasons were for not doing so, we do not consider that we can take this matter any further.

54 KIN 10147.

R 7 and the "funny" remark to Mr Maybin

76 As we have seen in the previous chapter, R 7 said that he was abused during two of the three periods he spent in Kincora, in the first by Mains and in the second by Semple. He was discharged at the end of the third and last period in January 1968 when he was nineteen and a half. Because of his experiences in Kincora he was concerned that his younger brother was going to be moved from the children's home that he had been in to Kincora when he reached the school-leaving age. R 7 was one of the clients of Mr Maybin, who was appointed a social welfare officer in the South Belfast division of the Belfast Welfare Authority based in their offices at Lower Crescent. Mr Maybin's recollection was that R 7 came to Lower Crescent and told him that he, "had not had a particularly good experience in Kincora himself", and made a comment that Mains was "funny". When asked by Mr Maybin what he meant, Mr Maybin said that R 7 did not elaborate. Mr Maybin told the Hughes Inquiry that he did not pursue the matter any further because he had already decided that R 7's brother would not be placed in Kincora but be fostered.

77 R 7 told the Hughes Inquiry that he did not say to Mr Maybin that Mains was "funny",[55] but even if he did use that expression, as Mr Maybin had already decided to foster R 7's brother, we agree with the Hughes Inquiry that it was not surprising that Mr Maybin did not pursue the matter further and we agree that he could not be criticised for not doing so. He could not have been expected to report the matter to Mr Mason, because he knew nothing of the 1967 complaints and therefore had no reason to attach any great significance to such a remark. We consider that he cannot be blamed for not passing the matter upwards. That Mr Maybin had not been told of the need to report anything of a suspicious nature regarding Mains is, we believe, an illustration of the failure of Belfast Welfare Authority to put in place a proper system whereby its officers were alerted to the need to make such reports. If such a system had been in place after 1967, or had Mr Maybin been alerted to the 1967 complaints, or both, then it is at least possible that he might have been more concerned by the "funny" comment, if it was made. However, to infer that this was an opportunity to uncover the behaviour of Mains and Semple would, in our view, be speculation.

55 KIN 75234.

Mr McCaffrey and the buttock slapping episode

78 From December 1969 Anthony McCaffrey was the Assistant Children's Officer with responsibility for field work services. Sometime thereafter he was asked by Mr Moore to investigate a complaint that Mains had slapped a boy on the buttocks, either the previous evening or two nights before. The Hughes Inquiry dealt with this episode at 3.133 and following of its Report. Mr McCaffrey spoke to Mains who said there had been some misbehaviour or horse play in the dormitory or upstairs, and a slap on the buttocks had been administered. Mr McCaffrey accepted this explanation for what the Hughes Inquiry described as a minor breach of the statutory regulations regarding corporal punishment in children's homes. It went on to consider in considerable detail how the incident was investigated, and we do not wish to add anything to their comments.

79 The significance of this episode was that Mr McCaffrey was unaware of the 1967 complaint, and Mr Moore, who was, did not make any connection with the 1967 complaint. Whilst we agree with the Hughes Inquiry that the slapping incident contained no obvious homosexual colour, and that Mr Moore should not have been expected to have linked it to the 1967 episode, it is significant that Mr McCaffrey was unaware of the 1967 episode. That is yet a further indication that proper procedures were not put in place after the 1967 complaints as they should have been. Had they been, then we would have expected an officer of his rank to have been made aware of such procedures following his appointment.

80 It would be wrong to imply that no steps were taken in respect of all of the recommendations Mr Mason made in his report on the 1967 complaints. It appears that steps were put in place for closer supervision of Kincora to be exercised thereafter. In his evidence on Day 218, Mr Bunting confirmed that when Mrs Wilson returned from undergoing professional training she was appointed to carry out this task from 1 January 1968. She made weekly visits to Kincora, the evenings being chosen because that was when the working boys would be there. With the civil unrest from October 1968 onwards there were occasions when the disturbed state of the city meant that she could not get to Kincora, and the Hughes Inquiry Report recorded at 3.129[56] that some of these

56 KIN 75240.

visits were carried out by Mr Mason because she was not able to do them herself for that reason. We consider the introduction of weekly evening visits was a suitable, and well resourced, level of monitoring, and one which was particularly commendable given the greatly increased pressure on the Belfast Welfare Authority due to the consequences of the civil unrest, such as a displacement of large numbers of families. Evening visits were appropriate because this provided an opportunity to develop relationships with the residents. However, none of these visits resulted in further allegations about Mains, or about Semple, coming to light.

PART FIVE

The 1971 complaints by R 8

81 In the previous chapter we referred to the experiences of R 8, who left Kincora on 22 August 1971 aged eighteen, having been a resident in Kincora for almost three and a half years. Shortly afterwards he wrote two letters about Kincora. One was addressed to his social worker and bore the legend, "to be handed in at Central Police Station".[57] That was never done. This letter was delivered by him by hand on 12 August 1971 to the Townsend Street office of the West Belfast Division of the Belfast Welfare Authority where Mrs Robinson, his social worker, was based. The Hughes Inquiry considered how that letter was dealt with at 3.144 to 3.147, and it is unnecessary for us to go over that ground again. It is sufficient to say that Mrs Robinson informed her superior, Miss Nicholl, and Miss Nicholl told her superior, Mr Bunting, when he returned to the office from leave. Mrs Robinson was informed by headquarters at College Street that she was not to do anything with the letter because a similar letter had been received at College Street and was being dealt with by Mr Mason, and so no further action was taken on the matter by the Townsend Street office.

82 It would seem that on 12 August 1971 R 8 delivered the other copy to the College Street headquarters of the Belfast Welfare Authority addressed to Mr Moore. He had been the Children's Officer, but had left in June to take up the post of Deputy Welfare Officer with the Down County Welfare Office. He was not replaced until Mr Bunting took up

57 KIN 10947.

the post of Children's Officer in October 1971. As the Hughes Inquiry explained at 3.148, although the letter was addressed to Mr Moore, it was passed to Mr Mason because Mr Moore had left. It is probable that this occurred on 12 August, although the first documentary record relating to it was not created until 23 August, the day the Town Clerk returned to his office after two weeks leave. The letter from R 8 which made its way to Mr Mason consisted of five large, hand-written sheets. It seems that R 8 was studying for, or had studied for, A-Levels to judge by his comments in a letter to KIN 342 written around the same time.[58] The letter to Mr Moore was well written and clear. In it he made no allegations about McGrath, who had only just started work at Kincora in June 1971, but he made a number of detailed allegations about both Mains, and to a limited degree, about Semple.

(1) They were incompetent.

(2) He and another boy R 38 had been sexually approached by another boy R 34 when they were in bed.

(3) When they told Mains about the behaviour of R 34 Mains only laughed, saying R 34 would grow out of it and didn't mean any harm.

(4) Mains had asked him to rub cream into his back whilst lying on his bed wearing only his underpants in return for five shillings.

(5) Mains persuaded him to sleep in his bed, but when he felt Mains's arm around him he fled to his own room.

(6) He implied that money he had earned at work had been misappropriated.

(7) He said Mains was regularly visited overnight by a friend R 2 with whom he had shared a bed in Mains's room in Kincora.

(8) R 8 concluded by saying:

> "I think his [Mains's] open approach to homosexuality is disgusting, he has a filthy mind, and a mind like that is not fit to look after growing boys".[59]

83 On 23 August Mr Mason spoke to the Town Clerk who directed his deputy William Johnston to take part in an investigation. R 8 was interviewed the same day by Mr Johnston, Mr Mason and Mr McCaffrey in Mr

58 KIN 11008.
59 KIN 11019.

Johnston's office at the City Hall. On 25 August Mr Mason prepared a memorandum, which he sent to the Town Solicitor Mr Young. In the memorandum Mr Mason commented that while R 8 did not appear a convincing witness he had reaffirmed the allegations contained in his letter. He also said that R 34, one of the boys referred to in the letter as having been the subject of similar approaches, had been interviewed on 24 August, and said he had experienced similar approaches. No statements had been taken from either boy, but Mr Mason sent with the memorandum the file relating to the 1967 complaints later described as "the Mason file". The memorandum contained the following crucial paragraph:

> "No other investigations have been carried out regarding the rest of the statements made, but it is thought that there are sufficient grounds to have the matter considered as one which should be referred to the police in view of the allegations which were made against the same officer in September 1967. A copy of the results of the departmental Inquiry into these allegations is contained in the file."[60]

84 It appears that a decision was made that the allegations were not to be referred to the police. This is a matter of inference because no record was made of any of these matters at the time the decision appears to have been made not to accept the recommendation that the 1971 allegations, taken together with the 1967 allegations, should be reported to the police. How and why that decision was made, and how it was communicated to Mr Mason, were the subject of exhaustive investigations by the RUC, by the Sussex Police and by the Hughes Inquiry. Despite these investigations, the absence of any written record explaining why the matter was not referred to the police means that it has been impossible to establish why that decision not to report the matter to the police was taken.

85 No evidence has emerged from our investigation to throw any new light on this crucial question, and we do not consider it necessary to review in detail the evidence given to, and the conclusions of, the Hughes Inquiry which had the advantage of hearing the evidence of those involved, apart from Mr Young, the Town Solicitor, and Mr Jamison, the Town Clerk. By the time of the Caskey Phase One investigation both Mr Young

60 KIN 11006.

and Mr Jamison were dead. That Mr Young and Mr Jamison did discuss Mr Mason's recommendation seems probable. The Town Clerk's diary records that the two were to meet on 28 September 1971 (and not 1970 as erroneously stated in the Caskey Phase One Report),[61] but the Caskey Phase One investigation found no indication that the meeting took place, or if it did, which subject(s) were discussed. Mr Mason conceded to the Hughes Inquiry that although he could not remember when, or how, or in what manner it happened, he must have been made aware by someone in authority in the City Hall that a decision had been made not to report the matter to the police.[62] We consider it reasonable to infer that Mr Jamison and Mr Young must have discussed the Mason file for such a decision to have been made. It is also reasonable to infer that any such discussion ought to have involved an assessment by the Town Solicitor as the senior legal officer of the City Council of the significance of the allegations made in 1967 and 1971, and whether they were capable of amounting to criminal offences.

86 Had such an assessment been made and discussed, in our opinion the only decision that could properly have been made would have been to refer the allegation to the police for further and more detailed investigation. The allegations suggested:

(1) Homosexual acts were occurring between Mains and R 2, when R 2 stayed overnight in Kincora.

(2) An indecent assault may have been committed by Mains on R 5 in 1967 when Mains put his hand down R 5's underpants.

(3) An indecent assault on R 8 may have been committed when Mains put his arms round R 8 when R 8 was sharing Mains bed.

(4) Possible indecent assaults had been committed by Mains when he persuaded R 8 and R 38 to massage his back with cream in circumstances that suggest Mains was sexually stimulated by this.

87 Although the views of the Town Solicitor would be of great weight in such discussions, we consider that the ultimate decision whether or not to refer the allegations to the police was one which ought to be taken by the Town Clerk as the chief executive of the Council, although he might have sought the views of the chairman of the Welfare Committee before he reached a final decision. Mr Mason's evidence to the Hughes

61 KIN 10077.
62 KIN 71915.

Inquiry suggests that, whatever the reasons were for not accepting his recommendation that the allegations be reported to the police, those reasons were never explained to him, although he does appear to have been made aware of the decision. In the absence of any such explanation, and in the absence of any contemporary documentation to explain the reasons for not reporting the allegations, we are left to speculate as to what the reasons might be. We should make it clear that the Hughes Inquiry considered whether there may have been an informal discussion with the police, but considered that the circumstantial evidence was not sufficiently strong to enable it to be inferred that the police were consulted in that way, and we see no reason to take a different view.

88 One reason advanced by Chris Moore in his book *The Kincora Scandal*, was that the Mason file "disappeared with no evidence of any response, let alone action from the Town Solicitor's office".[63] The Mason file did not "disappear", because, as the Hughes Inquiry established, and as we shall see, it remained in existence and was to play an important part in later events. Moore then speculated:

> "Indeed there may be a very simple explanation for this apparent "inaction", on the part of the Town Solicitor. The late John Young was a practising homosexual active in a small coterie of men which included Joe Mains. As the police were to discover, the third member of this group was a Unionist Councillor, Joshua 'Joss' Cardwell.
>
> With John Young, Semple and Mains formed a homosexual triumvirate that was undoubtedly able to keep complaints from the young male residents under wraps, at the same time safeguarding its own dark secret."

89 No evidence was given for the assertion that Mr Young was a practising homosexual, or active in a coterie consisting of himself, Mains and Councillor Cardwell. We shall refer to Councillor Cardwell later. Mr Young and Mr Cardwell are dead and we have seen no evidence that supports Mr Moore's assertion that any advice given by Mr Young, or action taken by him in this matter, may have been due to any improper motive on his part. Other possible reasons that could have contributed to the decision not to refer the allegations to the police were (1) a mistaken belief that the allegations were insufficient to constitute criminal matters suitable to be referred to the police; or (2) a desire

63 KIN 5051.

to avoid the embarrassment that the Welfare Authority could face if a criminal investigation were to be launched, something that could lead to the prosecutions of one of its employees. Our experience with other institutions in this Inquiry has shown that at that time it was a common view taken by institutions of all sorts that such allegations should not be referred to outside agencies including the police.

90 However, all of these explanations, including Mr Moore's, are speculative because of the absence of other evidence, and the absence of evidence means that we cannot account for the decision not to refer the matter to the police. What can be said is that we can conceive of no justifiable reason for not referring the matter to the police, and we are satisfied that **the failure to do so was a systemic failing by the Town Clerk and the Town Solicitor. Other systemic failings relating to the 1971 allegations were:**

(1) The failure to record the initial interviews of R 8 and R 38 so that these could be added to the Mason file before it was sent to the Town Solicitor;

(2) The failure to record the reasons for not referring the matter to the police; and

(3) The apparent failure to inform the chairman of the Welfare Committee of the allegations and the decision not to refer them to the police.

The approach of the Belfast Welfare Authority after the decision not to refer R 8's allegations to the Police

91 Considerable attention was devoted at the Hughes Inquiry to exploring with Mr Mason and Mr Johnston why they did not challenge, or at least ask for an explanation for, the decision not to refer the allegations to the police. In essence their response was that it was not their decision but that of their superiors, and it was not for them to challenge their superiors. We accept they cannot be criticised for not doing so, but there were steps which we consider Mr Mason should have taken as head of the Welfare Authority after he learnt of the decision not to refer the matter to the police. The first should have been to reiterate what he should have told Mains in 1967, but did not, namely that Mains should avoid doing anything with the residents that could lead to allegations of impropriety on his part. Secondly, he should have informed Mrs Wilson

and Mr Bunting, who had now succeeded Mr Moore as Children's Officer, of the allegations and instructed them to keep a very close eye on both Mains and Kincora. Thirdly, he should have put in place a formal procedure within the department in order to ensure that any further allegations about Kincora, and indeed any home or hostel that was the responsibility of the Welfare Authority, should be collated and referred to him, or in his absence to his deputy, for immediate attention. **We regard the failure to take each of these steps as systemic failings on the part of the Belfast Welfare Authority, and they replicate the inadequate steps taken by Mr Mason after the 1967 complaints.**

The transfer of the Mason file in 1973

92 Mr Mason retired on the reorganisation of local government in 1973 when the Belfast Welfare Authority disappeared and its responsibilities were subsumed into the new EHSSB. The EHSSB had a significantly wider geographical remit than its predecessor, because it took in large areas adjoining Belfast in Co. Down and Co. Antrim, and became responsible for hospitals and other aspects of medical services that were now combined for the first time with social services. Mr Bunting became an Assistant Director of Social Services in the EHSSB. He explained to us that this was not a managerial post because the District Social Services Officers, who were the rank below Assistant Director and now responsible for all of the personal social services, reported directly to the Director of Social Services.[64] His role, and that of his colleagues, was to be a professional advisor monitoring the work of the programme planning teams whose task it was to plan and deliver services.

93 Mr Bunting's recollection was that on the day Mr Mason retired he gave Mr Bunting the Mason file, and advised him to retain it in case anything further came up about Kincora. Although Mr Bunting had been told about the letter received in Townsend Street in 1971, he had not been otherwise engaged because the matter was being dealt with at headquarters. When he took over the post of Children's Officer in October 1971, despite being now responsible for all children's services in Belfast including Kincora, he had not been briefed on the 1971 allegations by Mr Mason, and he knew nothing about the previous allegations in 1967. He did know that Mrs Wilson was continuing the supervision of Kincora, and so the Mason file was not of any particular

64 Day 218, p.114.

significance to him in 1973. He therefore put it in a drawer and forgot about it until he was approached by DC Cullen of the RUC in 1976, something we deal with later in this chapter.

94 With the advantage of hindsight it is tempting to find that Mr Bunting should have familiarised himself with the Mason file when it was given to him in 1973. If he had done so, then no doubt he would have realised that procedures needed to be put in place to ensure that complaints and concerns about Kincora in general, and Mains in particular, were passed to the appropriate level of senior management, and then devised and put such procedures in place. However, we consider that would have been to ask too much of Mr Bunting, and we do not criticise him for not doing any of these things. He had no knowledge of the 1967 complaints, and only limited knowledge of the 1971 allegations. He had not been briefed about the outcome of the 1971 allegations, and in 1973 when handing over the file Mr Mason did not enlighten him in any way about what had occurred. Mr Bunting was in the midst of the creation of a completely new and complex organisation, which had a significantly different geographical and organisational remit. In all the circumstances we do not consider that he can be criticised for failing to enquire further into the significance and contents of the Mason file. If he had, because he did not have operational responsibility for Kincora in the new structure, the appropriate step would have been to pass it to the District Social Services Officer responsible for the East Belfast & Castlereagh Unit of the EHSSB within which Kincora now fell.

PART SIX

The anonymous 1974 phone call about McGrath

95 On 23 January 1974 an anonymous phone call was received by Mr Colin McKay in the Holywood Road office of the EHSSB. He was a senior social worker in that fieldwork office, which, although not far from Kincora, was not responsible for Kincora because the hostel was the responsibility of a different department of the EHSSB. In 1982 Roy Garland told D/Supt Caskey that he made an anonymous call to Holywood Road Social Services, and we are satisfied that it was probably he who made the 23 January 1974 call. Later in this chapter we examine Mr Garland's role in these events. Mr McKay reported the call to his superior, Brian Todd, who then telephoned Mrs Mary Wilson. It appears that she was

the first person to make a note of what had been said by the anonymous caller, to judge by the outcome of subsequent police enquiries following remarks Mr Todd made in an interview carried in the Social Work Today issue of 12 January 1982. We shall have occasion to refer to that publication later in this chapter.

96 Mrs Wilson was at home when she received the call from Mr Todd, who recounted to her what Mr McKay had told him the anonymous caller had said to him. Because the details were being recounted third hand to Mrs Wilson they may have become somewhat distorted, but her note of what she was told was as follows:

> "Mr McGrath (house-father) had made improper suggestions to the boys; had gone to live in the hostel for this purpose and had written a note to one of the boys making improper suggestions".[65]

97 These allegations were significant for a number of reasons. Firstly, they were the first allegations received by the EHSSB or its predecessor relating to McGrath. Secondly, they did not allege homosexual acts by McGrath involving any of the boys in Kincora, but "improper suggestions". Thirdly, McGrath was said to have made such improper suggestions in a note to one of the boys, suggesting the caller had specific information about the existence of such a note. Fourthly, the caller alleged McGrath was living in Kincora to enable him to make such improper suggestions. Mrs Wilson immediately phoned Kincora and checked with Mains to be told that McGrath did not sleep in the hostel at any time.

98 It was not until 29 January that Mrs Wilson went to Kincora. McGrath was not there because he was not due to work at that time and she spoke to Mains. He told her that the allegations were untrue, and there was a political reason for them. She recorded, "apparently the police had a similar call about Mr McGrath a few months ago and told Mr Mains about it, and their opinion was that someone was trying to get at McGrath because of his connection with the Orange Order".[66]

99 She and Mr McKay went to Kincora on 4 February 1974, when they spoke to McGrath. Her notes of that occasion record that McGrath was not surprised when she told him why they were there. That might suggest that he had already been told what the allegations were by Mains. In any event, he said that he had received a copy of an anonymous letter

65 KIN 114014.
66 KIN 114015.

saying he was a homosexual. This information was a new element in what was being recounted to Mrs Wilson and Mr McKay. He then went on to attribute the allegations to "an organisation he was associated with", presumably meaning Tara. He said he was probably in danger because of his connection with the Orange Order, and denied making any improper suggestions to boys in the hostel.

100 Mr McKay and Mrs Wilson both accepted his explanation, and felt there was no need to pursue the matter any further. Mr McKay had visited Kincora on several occasions in the course of his work and everything appeared normal to him on those occasions. Mrs Wilson said to the Hughes Inquiry that this was her first experience of an allegation of sexual impropriety in a boys' home, although she went on to explain she had investigated an "unspecified" complaint about Mains previously, but she thought this was a coincidence. It did not occur to her that two different members of staff would be involved in the same practices within the same home. She trusted Mains, and this was the first time she had heard anything about McGrath, who was a family man that seemed concerned about the boys in his care.

101 Before she went to visit McGrath, Mrs Wilson had spoken to her superior, Mr Scoular, and she reported back to Mr Scoular after the visit. Neither she nor Mr Scoular knew anything about the 1967 or 1971 allegations against Mains, nor did they know anything about the Mason file. Despite McGrath's admission that there had been an anonymous letter alleging he was a homosexual, and Mains telling Mrs Wilson that there had been an earlier phone call to the police, no significance appears to have been attached by either of them to the conjunction of a number of different allegations at this time. Nor did Mr Scoular report any of this to his superiors, presumably because neither he nor Mrs Wilson felt that there was any substance to the allegations, especially in the light of the incorrect allegation that McGrath had been sleeping in the hostel. Had they known about the earlier allegations and about the Mason file, as they should have if a procedure had been put in place by Mr Mason for allegations or concerns about Kincora to be reported to the senior official responsible for the hostel, we accept a very different approach may have been taken. This is a further illustration of the way in which matters were being dealt with by officials of the EHSSB in ignorance of the 1971 allegations, and an example of the significance of the failure to put proper reporting procedures in place. We agree with the Hughes

Inquiry that the allegations should have been referred to the Director of Social Services, and then reported to the police. No matter how plausible McGrath appeared, the allegation that he had written a note containing improper suggestions to a boy, taken with the realisation that there had already been a complaint to the police about McGrath, was sufficient to require the allegations to be reported to the police, even though they were from an anonymous source, something which creates considerable difficulties for the police when seeking to investigate any form of allegation. Notwithstanding that difficulty, **we regard the failures to report the matter to the Director of Social Services, and to the police, to be systemic failings on the part of the EHSSB.**

The complaints by R 15 in May and September 1974

102 R 15 and his brother had been placed in care under Fit Person Orders. The Hughes Inquiry recorded that conditions in the family home were poor, and there had been a lack of cooperation with Social Services and other agencies such as other agencies dealing with Public Health. R 15's father gave evidence to the Hughes Inquiry and agreed that it would be reasonable to describe his wife as "having had a running battle with the Welfare Services for many years".[67] This difficult background undoubtedly influenced the way in which complaints made by R 15 in May and September 1974 were viewed by the EHSSB staff.

103 R 15 was grabbed by the genitals by McGrath in November 1973, and in 1981 McGrath pleaded guilty to a single charge of indecent assault on R 15. R 15 told his brother about the incident the next day, and told Mains about it the day after that. Mains said he would do something about it, but he did not report the matter to his superiors as he should have done. It is unclear whether it was R 15 or his brother who told their mother about the incident, but R 15's father told the Hughes Inquiry that he and his wife thought R 15 had made the story up and so did not pursue the matter. Following a second incident where McGrath again grabbed R 15 by the genitals, which R 15 also told his brother about, his brother told their mother, and she then made a complaint about McGrath to the EHSSB.

104 Her complaint was made to the local office of the North and West Belfast District of the EHSSB at College Street on 17 May 1974. It was received by Miss Sharon McClean (later Mrs Grey), who was a

67 KIN 75262.

trainee social worker. She said she would speak to Mains about the allegations. She consulted her supervising senior social worker Ronnie Orr, and some days later she telephoned Mains. This was during the Ulster Workers' strike when there was widespread disruption in Belfast and other areas, and travel across the city was difficult. Mains told her that R 15's mother had made an identical complaint to him; he had questioned McGrath and decided there was no truth in the matter. It seems that Miss McClean saw R 15 sometime later in the presence of his mother, but was unable to obtain any more information from him.

105 Nothing further was done until R 15's mother called again at College Street in September 1974, probably on 16 September. Miss McClean saw her and recorded that his mother, "covered the same ground as always", and said that McGrath had tried to interfere with R 15 again. While this would suggest a third assault, R 15 told the Hughes Inquiry that there were only two episodes. On 17 September Mr Orr met R 15's mother, but it would seem from notes made of that meeting that there was no reference to the McGrath complaints, but the case of R 15 was discussed in general terms. On 20 September the decision was made that R 15 and his brother would be discharged from Kincora provided they lived with their sister.

106 The Hughes Inquiry concluded that the complaints were treated with scepticism by Mr Orr because of the history of difficult relations between the family and Social Services. We agree, and we also agree that he should have taken part in the interview of R 15 and his mother by Miss McClean in May 1974. He was much more experienced, and that experience might have enabled him to draw out more information from R 15. **We consider his failure to be more closely involved was one of several systemic failings in the way these complaints were dealt with. The other systemic failings were:**

(1) Mains did not make a written record of the complaint to him by R 15;

(2) Mains did not report R 15's complaint, nor the complaint made to him by R 15's mother, to his line management; and

(3) the College Street office did not refer the complaints it received from R 15's mother in May and September to Residential & Day Care Management in the East Belfast & Castlereagh District, as the district responsible for Kincora.

The anonymous phone call by Colin Wallace in 1975

107 In the next chapter we examine a claim by Colin Wallace that in 1975 he made an anonymous phone call about Kincora to the Welfare Department. It is sufficient to say at this stage that no trace of any such call has been found.

Mr Maybin's evidence about rumours in 1975

108 In 1975, and for sometime thereafter, Michael Maybin was an assistant principal social worker with the EHSSB in fieldwork services in East Belfast and Castlereagh. He had worked in Kincora in the summer of 1966 for a short period helping Mains in the evenings because Kincora was short staffed at the time. He had also been the social worker of R 7 in the 1960s after R 7 reached school-leaving age. R 7 had been in Kincora for several periods in the mid-1960s. When Mr Maybin was interviewed by the Sussex Police in September 1982 he told them that on a number of occasions after he transferred to the East Belfast and Castlereagh District in 1975, he heard a rumour within social work circles that Mains was a homosexual. He also said that in the late 1970s he heard another rumour that Mains was sexually interfering with the boys in his custody at Kincora. He said he could not recall passing any of this information to his seniors or anyone else.[68] He told the Hughes Inquiry he regarded the 1975 rumour as "low level gossip" with no detail or supporting evidence.[69]

109 We agree with the Hughes Inquiry that these rumours should have been passed to senior management within the East Belfast and Castlereagh District. The HSCB accepts this should have been done. We consider that **the failure by any of those in social work circles, whether in the EHSSB or elsewhere, who were privy to such rumours to report them to their senior managers or to an appropriate person in the EHSSB if they themselves were not employed by that Board, amounted to a systemic failing.** Whilst of limited value in themselves, had these rumours been reported they would have provided an element of additional material showing that there were concerns about Kincora. We also agree with the Hughes Inquiry that as these rumours only came to light because Mr Maybin disclosed them to the Sussex Police he is to be commended for doing so.

68 KIN 40920.
69 KIN 75267.

The information received from Elizabeth Fiddis in 1976

110 Mrs Elizabeth Fiddis was a health visitor employed by the EHSSB in the East Belfast & Castlereagh District. As such, her work and her responsibilities did not extend to childcare matters relating to Kincora. Sometime in the first half of 1976 during a social occasion unconnected with her professional duties she heard a vague rumour which she understood emanated from Valerie Shaw, a lady she had never met but knew to be a Christian missionary to the Jews. Miss Shaw was also connected with the late Dr Ian Paisley MP at one time, and in later years there was a dispute between them as to what she did or did not say to him about Kincora. That dispute is not relevant to our investigations as we are concerned with what Social Services, the police and the security agencies knew, or did not know, about sexual abuse in Kincora. As we shall see, Miss Shaw also appears in another context relevant to Kincora.

111 The rumour that Mrs Fiddis heard on this occasion was that there was some unspecified form of sexual malpractice going on at a home in East Belfast, although she did not know the name of the home.[70] The rumour was supposed to have come from Valerie Shaw, and because Mrs Fiddis knew of Valerie Shaw this gave added weight to the concern Mrs Fiddis felt about this vague rumour from both a moral and professional prospective. She decided that she should pass the rumour to colleagues in the EHSSB, and so she went to the Holywood Road office where she spoke to Marian Reynolds, who was the duty social worker in the office on that day. The Hughes Inquiry concluded that this was in either February or March 1976. There were some differences between the recollection of Mrs Fiddis and Miss Reynolds as to what was said on that occasion, and the Hughes Inquiry concluded that Miss Reynolds's recollection was substantially correct. Although Mrs Fiddis may not have mentioned either Mains or Kincora by name, Miss Reynolds was able to identify both from what Mrs Fiddis told her. Miss Reynolds said that Mrs Fiddis told her she had obtained some information that a boy had received some inpatient treatment for depression at Purdysburn Hospital. The Hughes Inquiry concluded that this person was possibly R 2, who did receive psychiatric treatment there in 1973 and again in March 1976.

70 KIN 72782.

112 At this stage, Miss Reynolds had only limited knowledge of Kincora and so she suggested Mrs Fiddis speak to Hilary Reid (now Dr Hilary Harrison) who Mrs Fiddis knew both professionally and socially. Miss Reid arrived in the office later and was present when Miss Reynolds rang Miss McGrath. Miss McGrath was the newly appointed Principal Social Worker (Residential & Day Care) for East Belfast & Castlereagh and as such was responsible for Kincora. She was based in the offices at Purdysburn Hospital. There was some confusion as to whether it was left that Miss McGrath was to contact Mrs Fiddis or Mrs Fiddis was to contact her. That is of no significance, because Miss McGrath accepted that she received Mrs Reynolds's phone call. Miss McGrath told the Hughes Inquiry that the information she received related to sexual impropriety, but she had no clear recollection of the detail. She did not make a note of what she was told, and did not take the matter any further because the call went out of her mind. She explained that she was new in her post and was under extreme pressure at the time; the office was under staffed and she accepted that she may not have allowed enough time to talk to Miss Reynolds, and she did not appreciate the importance of what she was being told.[71] Because she did not remember to do so, the matter was never taken forward, and so she did not inform her superior, Mr Clive Scoular, of the call.

113 We consider **there were a number of systemic failings in the way Mrs Fiddis's report was dealt with by the EHSSB.**

(1) No written record was made of what she had to say.

(2) Miss McGrath did not follow the matter up by contacting Mrs Fiddis to see whether she could add anything to the account she had given to Miss Reynolds.

(3) Miss McGrath did not tell Mr Scoular about the call.

PART SEVEN

March 1976 and the visit by DC Cullen

114 DC Cullen contacted the EHSSB in March 1976 and spoke to Mr Bunting about allegations that had been made about McGrath to DC Cullen. We shall return to this when we consider the way the RUC dealt with the information it had received about McGrath, but at this stage we examine how the EHSSB responded to what it was told by DC Cullen. To put

71 KIN 75269.

the matter in context it is necessary to explain briefly that in 1974 Roy Garland made a number of allegations about McGrath to DC Cullen, who immediately contacted Assistant Chief Constable Meharg, who was the head of the Crime Department of the RUC at the time. We examine later in this chapter why these allegations were not properly investigated in 1974. Roy Garland spoke to DC Cullen about the matter again in 1976; DC Cullen again consulted ACC Meharg who instructed him to contact the EHSSB.

115 As a result of ACC Meharg's instructions, DC Cullen contacted the EHSSB and met Mr Bunting on 19 February 1976. Mr Bunting was the Assistant Director in charge of Family Child Care Services in the EHSSB. During their meeting DC Cullen gave Mr Bunting a general outline of the nature of his enquiries into McGrath, and in the course of the discussion he referred to Mains as the senior member of the residential staff at Kincora. The reference to Mains prompted Mr Bunting to recall the Mason file, which he then produced to DC Cullen and allowed him to read it. DC Cullen asked him for a copy. Mr Bunting explained that he considered he did not have authority to provide that but he would seek instructions. He subsequently contacted Mr Gilliland, who was the Director of Social Services, and told him about the meeting with DC Cullen.

116 At this point in the sequence of events we emphasise the following aspects of what the EHSSB and the RUC learnt as a result of the meeting between Mr Bunting and DC Cullen. Until then Mr Bunting and Mr Gilliland had no reason to believe that there were any concerns about Kincora, because none of the matters to which we have referred that occurred after 1971 had been communicated to them. When Mr Bunting received the Mason file from Mr Mason in 1973 he put it in a drawer in his office where it lay until Mr Bunting produced it to DC Cullen during the meeting. The comments by DC Cullen revealed that there were also concerns about McGrath who was the subject of a police investigation. This meant that the EHSSB were now made aware of fresh allegations post-dating the 1971 allegations, although at that point DC Cullen had revealed very little detail about the more recent allegations. It is clear that Mr Bunting immediately appreciated that the Mason file could be relevant to the matters being investigated by DC Cullen because he remembered the existence of the file, produced it and showed it to DC Cullen. DC Cullen, and the RUC in the broader sense, learned for the first time that there

had been more allegations about Kincora that were known to the EHSSB but which had not been revealed to the police. These related to Mains, and so DC Cullen now knew that there were allegations about a second member of the staff at Kincora. This information was clearly relevant to, and added a new dimension to, his investigations into McGrath.

117 Mr Gilliland and Mr Bunting met DC Cullen on 15 March 1976. They agreed DC Cullen could copy the Mason file and he took it away for that purpose, returning the original in due course. By the end of both meetings the EHSSB had only limited information about the nature of DC Cullen's investigations. He had told them that these were extremely confidential, that his senior officers were not aware of the investigation but he was reporting to ACC Meharg at RUC Headquarters. During their first meeting he told Mr Bunting that he was inquiring into homosexuality and paramilitary activities, and that "prominent people" were involved. At some stage he also referred to a letter, or letters, written by McGrath which indicated homosexual tendencies. He expressed concern that McGrath should be working in Kincora, because of the allegations made to him by his informant about McGrath's homosexuality. It is unclear whether DC Cullen went into detail about what that may have involved. DC Cullen, unfortunately was not in a condition to be interviewed for the purposes of our Inquiry and sadly has since died. He told the Hughes Inquiry that he would have told Mr Bunting about the type of behaviour in which McGrath had been engaged in the past, but Messrs Gilliland and Bunting said the only detail they received was about the letters, and the Hughes Inquiry was inclined to accept their evidence.[72] We therefore proceed on the basis that the recollection of Messrs Gilliland and Bunting is to be preferred.

118 It was common ground that DC Cullen accepted that Mr Gilliland and Mr Bunting would have to inform Mr Scoular of the allegations because he was the District Social Services Officer responsible for Kincora. Either at the second meeting, or subsequently, but more likely afterwards, DC Cullen was provided with a list of all the boys who had been discharged from Kincora from the time McGrath started working there until that date.[73] At the end of the 15 March meeting it was agreed that DC Cullen would inform them of any information that would enable them to take action in relation to the staff at Kincora.[74]

72 KIN 75272.
73 KIN 72409.
74 KIN 75272.

The EHSSB actions after the meeting with DC Cullen

119 Mr Bunting briefed Mr Scoular on the Cullen/Meharg investigation when he went to Mr Scoular's office, and he gave Mr Scoular a copy of the Mason file. Mr Scoular was asked to prepare the list of those discharged from Kincora during McGrath's time, and he did so. It therefore seems the list was provided to DC Cullen after the 15 March meeting. Mr Scoular told the Hughes Inquiry that although he was not given any written directions or advice as to the action to take with the information he was given, he was told that he was to brief his senior residential & day care management staff about the matter. However, Mr Scoular did not tell Mr Bunting about the anonymous phone call received by Mr McKay at the Holywood Road office on 23 January 1974, nor did he make any reference to Mrs Wilson's subsequent investigation. Whilst an anonymous call is by its very nature difficult to assess, and may, depending on the detail of its content, be of little or no value to the person to whom it is made, had Mr Bunting been told about that call it would have provided another piece of evidence to be added to the Mason file. Whilst it is unlikely that it would have been regarded as significant by itself, had it been added to the information from DC Cullen it may have caused some additional concern to Mr Bunting and Mr Gilliland. We consider that **it was a systemic failing by Mr Scoular not to tell Mr Bunting about the January anonymous call when Mr Bunting briefed him on the Cullen/Meharg investigation.**

120 We examine later what happened afterwards so far as the RUC and the Cullen/Meharg investigation was concerned. We are satisfied that the EHSSB was in a difficult position after the meeting on 15 March. Mr Gilliland and Mr Bunting had provided DC Cullen with the Mason file and he had made a copy. They also provided him with a list of residents of Kincora that he requested. They knew that a police investigation of a highly confidential nature was underway which was being overseen by an assistant chief constable. Whilst this investigation concerned one of their staff at the hostel he was apparently not the only person, because they had been told that others were involved but were given no information about the others, other than they were "prominent people". Nor were they told what the involvement of these "prominent people" with McGrath or Kincora might be, other than the investigation was into homosexuality and paramilitary activities. It would seem that they were told nothing more about the alleged homosexuality other than McGrath had written letters which indicated homosexual tendencies, although

DC Cullen had expressed concern that McGrath was working in Kincora. This concern was presumably to suggest at least that a homosexual male could pose a threat to the boys in his care. Although this might be a concern shared by many at the time, it was not something that was justifiable, or which a responsible employer in the childcare field could regard as sufficient in itself to take action against the employee concerned. In any event, DC Cullen also told them that the allegations related to some time in the past and that there was no allegation of homosexual activities at Kincora.[75]

121 If the EHSSB were to take independent and overt action to question McGrath or other staff or residents at Kincora about homosexuality, this might well interfere with the police investigation, which clearly should have taken precedence. However, there were some steps that could have been taken, and as we have already explained, Mr Bunting briefed Mr Scoular, but no written directions were given to Mr Scoular as to what was to be done. Mr Gilliland told the Hughes Inquiry he gave a verbal direction through Mr Bunting that closer supervision of Kincora should take place. Mr Higham was an assistant principal social worker who was appointed Mains's line manager in the Residential & Day Care management team in August 1976. After his appointment, the frequency of inspections of Kincora increased and exceeded the statutory requirement of monthly visits. The Hughes Inquiry noted it was not unusual for three or four visits to be recorded in a single month.[76] However, as we now know, these visits did not deter McGrath from committing further offences.

122 The usefulness of such visits may have been reduced, because it is unclear exactly how much information Mr Scoular did pass on to his subordinates, who were directly responsible for Kincora. Miss McGrath was responsible until she was succeeded by Mr Higham in August 1976. Mr Scoular told the Hughes Inquiry that Miss McGrath was made aware of the Cullen/Meharg investigation and shown the Mason file in the spring of 1976. She said she learned of the Cullen/Meharg investigation through Mr Bunting, and her recollection was that she was shown the file after Mr Higham read it. Mr Higham said he had no information about suspected homosexual activity at Kincora before October 1977, and did not become aware of the Cullen/Meharg investigation, or see

75 KIN 75272.
76 KIN 75253.

the Mason file, until then.[77] Whatever the correct position was, we accept the situation was a delicate one, and that care needed to be taken to ensure that information about the Cullen/Meharg investigation should not be widely or loosely disseminated. Nevertheless, we regard it as unacceptable that there was any confusion or uncertainty about who had seen what. This should not have occurred if clear written instructions had been issued to the Residential & Day Care management team explaining exactly what was to be done and why.

123 These were not the only unsatisfactory aspects of the handling of the information from DC Cullen on the part of the EHSSB. At least the chair of the Personal Social Services Committee (PSSC) of the Board, and the chair of the Board should have been informed on a confidential basis. Secondly, the Department of Health and Social Services should have been informed. It was unsatisfactory that none of these individuals or bodies were alerted to what was happening, even if that was done on a very limited basis without mentioning Kincora itself, or referring to McGrath or Mains. Depending upon the outcome of the Cullen/Meharg investigations this was potentially a very serious matter for the Board, and both the chair of the PSSC and the chair of the Board and the Department should have been informed on a confidential basis of at least the outline of what was happening at that stage.

124 Mr Bunting told the Hughes Inquiry that following the 17 March meeting he made three or four telephone calls to DC Cullen, who agreed that was the case. Mr Gilliland, who was aware of them, suggested the calls may have extended over more than eighteen months. If that was the case, it would suggest that the last call may have been made in the autumn or early winter of 1977. No record was made of these calls. Mr Bunting's evidence to the Hughes Inquiry, which we infer it accepted, was that in the last conversation he had with DC Cullen he was told that a report had gone to ACC Meharg, and that there was no evidence on which the Board could take action. Mr Bunting also got the impression that either DC Cullen's informant could not substantiate what he had said, or had ceased to provide information.

125 As we shall see, there is no evidence that any final report was ever submitted to ACC Meharg, or anyone else in the RUC, by DC Cullen. ACC Meharg is dead, and DC Cullen was unfit to give evidence and has

77 KIN 75274.

since died. It is therefore impossible for us at this remove to resolve how Mr Bunting came to be given such information or impression, because such information as is now available suggests the Cullen/Meharg investigation simply petered out without ever being brought to a formal or final conclusion.

126 We are satisfied that more should have been done by the EHSSB to find out from the RUC what stage their investigation had reached, and when the outcome might be known. Despite the sensitivity of that investigation, Mr Gilliland and Mr Bunting had been told that it was being overseen by ACC Meharg, and we consider that it was not enough to phone DC Cullen from time to time once an extended period had elapsed. We consider a formal written enquiry should have been made to ACC Meharg by Mr Gilliland as the Director of Social Services asking what the position was, and at the very latest such a letter should have been sent in March 1977 when a year had gone by.

127 Once Mr Bunting learned from DC Cullen that there was no evidence on which the Board could take action it is unsurprising that the EHSSB did not take further steps. All it had been told was that McGrath was suspected of being homosexual on the basis of letters written to someone in the past. There was no suggestion that that person had been a resident of Kincora and, as the Hughes Inquiry explained, DC Cullen did not transmit any allegation that McGrath was engaging in homosexual activity with residents at Kincora.[78] In our view the end result of the Cullen/Meharg investigation so far as the EHSSB was aware was that the only allegation was that McGrath was suspected of being a homosexual. The Board had never seen the letters on which the suspicion was based. Other than to take steps to ensure that McGrath and Kincora were closely monitored and that any further suspicions or concerns about McGrath's behaviour, or indeed the behaviour of Mains, were reported to senior management at Board headquarters there was nothing they could do. This was because there was nothing on which an internal investigation, let alone possible disciplinary action, could be based because an allegation of homosexuality alone would not justify such an internal investigation unless there was a sustainable allegation of improper behaviour of some sort by McGrath or Mains, and so far as the Board's officers were aware there was none. Had the Board officers been told of the rumours and anonymous phone calls received

78 KIN 75276.

by their subordinates in recent years that might well have increased their concern, but they needed more than rumours lacking specific detail before they could take disciplinary action.

128 Nevertheless, as we have indicated, there were a number of unsatisfactory aspects to the response of the EHSSB to the news of the Cullen/Meharg investigation, **and we consider that there were the following systemic failings in their response.**

(1) The Director of Social Services should have given clear written instructions to Mr Scoular to (a) increase supervision of Kincora, McGrath and Mains; and (b) to share the Mason file with Miss McGrath and Mr Higham when he succeeded her.

(2) Mr Scoular should have told Mr Bunting about the January 1974 anonymous phone call.

(3) (a) The Chairman of the EHSSB, (b) the Chairman of the Personal Social Services Committee, and (c) the DHSS, should all have been informed of the existence of the Cullen/Meharg investigation on a confidential basis, and that it involved a member of the EHSSB staff working in a residential hostel.

(4) Written approaches should have been made by the Director of Social Services to ACC Meharg at regular intervals, starting no later than 17 March 1977, in order to find out what was happening to the Cullen/Meharg investigation.

(5) All communications within the Board relating to these matters should have been properly minuted or recorded and added to the Mason file.

Valerie Shaw and Rita Johnston

129 In 1976 Rita Johnston was employed by the EHSSB and was in charge of the St Martin's Day Centre in East Belfast, which provided occupation for adults through various crafts. Although employed by the Board, Mrs Johnston was a handicrafts instructress and not a social worker. The Day Centre was also the responsibility of the East Belfast & Castlereagh District Residential & Day Care management team. The Hughes Inquiry established that in October or November 1976 Mrs Johnston was introduced to Valerie Shaw at a prayer meeting in the home of a mutual friend. Mrs Johnston was told by Miss Shaw that the wife of R 36, who was an outpatient at the Day Centre, was distraught because her

husband was suicidal as a result of a previous homosexual relationship with McGrath. This man had never been a resident in Kincora, and the relationship, which developed elsewhere, related to the 1940s and 1950s. Significantly, there was no allegation of homosexual misconduct occurring at the hostel.[79] Miss Shaw also told Mrs Johnston about the letters from McGrath which DC Cullen had described to Mr Bunting, but she did not show them to Mrs Johnston. Miss Shaw said McGrath was employed in a boys' home somewhere on the Newtownards Road, but it was not clear to the Hughes Inquiry whether she mentioned Kincora by name.

130 Mrs Johnston suggested to Miss Shaw that Miss Shaw contact the management at Purdysburn, although she could not remember if she gave Mrs McGrath's name as the person to contact there. In any event, Miss Shaw did not follow up that suggestion. However, Mrs Johnston checked with R 36's social worker in the psychiatric unit at Purdysburn Hospital because she was concerned that R 36 had access to dangerous tools in her Day Centre. His social worker reassured her that R 36 was not a danger to himself or others. Miss Shaw and Mrs Johnston met again at a subsequent prayer meeting in February 1977; their recollections as to what was said on that occasion differed. Mrs Johnston said she received very little information from Miss Shaw, and in our view she acted entirely properly by suggesting to Miss Shaw that she should approach management in Purdysburn. As we have already recorded, Miss Shaw decided not to do that. We do not consider that Mrs Johnston should have taken any further steps.

The Reverend Martin Smyth MP

131 The Reverend Martin Smyth told the Hughes Inquiry in a written statement that in 1976 he telephoned the EHSSB because of concerns he had about McGrath as a result of what both Miss Shaw and another (unnamed) source said to him. He said he believed that he spoke to a Mr Jackson at the University Street office of the Board, but as there is no record of such a call, and the police enquiries at the time failed to identify anyone called Jackson who could have been the person concerned, we cannot take the matter any further.

79 KIN 75277.

Anna Hyland and R 18

132 In the previous chapter we examined R 18's experiences in Kincora. Although it was later established that McGrath engaged in sexual activity with him, and McGrath subsequently pleaded guilty to a charge of gross indecency involving him, in August 1977 R 18 gave a much less explicit account to Mrs Hyland. She was his social worker at the time, and during a discussion on 16 August 1977 when asked how he was getting on with the staff at Kincora R 18 was very hesitant. After some probing on her part, he said he was concerned about the attitude of one staff member towards him. Although she did not name McGrath as the person in her memorandum of 9 September 1977 it is common cause that the staff member was McGrath. R 18 told her that McGrath had been having long and intimate discussions with him about sex, and had "embraced" him on a number of occasions. R 18 said that he had told Mains about this, and emphasised to Mrs Hyland that he did not want there to be any unpleasantness about it, or for McGrath to lose his job. She gave R 18 advice as to how to deal with the matter if this should happen again. She spoke to R 18 again on 1 September, and he told her there had been no more incidents, he had had little contact since with McGrath, and was no longer worried about the situation.

133 Although her memorandum of 9 September 1977 does not say so, Mains later accepted he had been told these things by R 18, but had done nothing about it until Mrs Hyland spoke to him. She discussed these matters with Mains on 17 August, and he said he would consider whether he should discuss the matter with Mr Higham, who, it will be recalled, had succeeded Mrs McGrath as the line manager for Kincora the previous year. Mrs Hyland did not leave the matter there because she discussed it with her principal social worker. They agreed that McGrath's actions could simply have been an affectionate response, and that the evidence from R 18 was not sufficient to suggest any kind of improper assault. They agreed she should mention the matter informally to Mr Higham.[80]

134 A meeting took place between Mrs Hyland, Mr Higham and Mains on 12 October 1977. Mains produced a report dated 11 October 1977 in which he referred to the "embracing", but added some significant detail about the second incident, which he said happened in the bathroom

80 KIN 11047.

while R 18 was only wearing pyjamas. Mains referred to that embrace as R 18 being "caressed", which implies more significant physical contact than a mere "embrace". Even more significantly, Mains recounted a different episode when R 18 alleged that McGrath approached him in the bathroom whilst R 18 was applying medical cream to his body, saying to R 18 that he would look better without the towel around his waist, and that he (McGrath) had been a qualified masseur. R 18 also alleged that McGrath then attempted to massage R 18's shoulders.[81]

135 Mr Higham sent a report of the meeting of 12 October, together with the memoranda from Mrs Hyland and Mains, to Mr Scoular. In his covering memorandum, Mr Higham described what happened between R 18 and McGrath as "questionable". He concluded that, "nothing of a sexual nature appeared to happen at any time" which seems a surprising conclusion in the light of Mains's reference to McGrath's alleged action in saying R 18 would look better without the towel round him and massaging R 18's shoulders. Mr Higham recommended that whilst no, "direct action should be taken against Mr McGrath", Mains and Mrs Hyland, "would keep a particularly close eye on the whole situation".[82] Nowhere in Mr Higham's memorandum did he suggest that Mains had been asked why he had not drawn these episodes to Mr Higham's attention. In his response to the Inquiry Warning Letter Mr Higham explained that at the time he assumed Mains was fulfilling his duties as the officer in charge and could be trusted with regard to his dealings with McGrath. Therefore there seemed no need to question Mains's actions which appeared to be appropriate. Mr Higham observed "It was assumed that Mains was a watchdog in the situation and not a perpetrator himself." We accepted this explanation.

136 Mr Scoular responded in a memorandum dated 20 October 1977. In view of its content this deserves to be quoted in full:

> "I have read the reports you sent me concerning [R 18]. I am still unhappy about Mr McGrath's relationships with the boys in the Hostel. Whilst I appreciate that his 'extra curricular' activities have probably some bearing on the situation, I feel we will have to 'grasp the nettle' and in some way discuss the whole situation with Mr McGrath in the near future. I well appreciate that the situation is further complicated by Mr Mains's reticence about freely discussing

81 KIN 10960.
82 KIN 10958.

what goes on in Kincora with you. I think it would be valuable for Mrs McGrath and yourself to have an early discussion with me.

As I mentioned to you yesterday I find the content of Mrs Hyland's report and the content of that prepared by Mr Mains to be almost two different stories. I will try and make some discrete enquiries and see what I can find out."[83]

137 We consider the following aspects of this memo to be significant:

(1) Mr Scoular was unhappy about McGrath's "relationship with the boys in the hostel", implying McGrath's relationship with others apart from R 18.

(2) He appears to have recognised, albeit in an oblique fashion, that Mains was not prepared to freely discuss what was going on in Kincora with Mr Higham, which was presumably an acknowledgment that Mains had not reported these matters as he should have done to Mr Higham.

(3) That it was necessary to, "grasp the nettle", that is to discuss the whole situation with McGrath in the near future.

(4) His reference to McGrath's "extra curricular activities" appears to be a reference to his paramilitary involvement with Tara, and we return to this shortly.

138 By this time Mr Scoular was aware of the Mason file and the Cullen/Meharg investigation, and had been instructed to keep a close watch on McGrath and Kincora. In our view he should have immediately referred this matter to Mr Bunting, together with the memoranda from Mrs Hyland and from Mains. He did not do so, nor did he "grasp the nettle" as he had accepted was necessary. We are satisfied that a contributory factor to his failure to do so, if not the entire reason, lies in his reference to McGrath's "extra curricular activities". The Hughes Inquiry concluded that:

"Mr Scoular was apprehensive of Mr McGrath's alleged paramilitary links to some degree, and that this, in conjunction with the fact that the homosexual implications of the [R 18] and [Richard Kerr] cases were unsubstantiated, clouded his judgement as to whether Mr McGrath should be interviewed or these cases should be referred to Board Headquarters".[84]

83 KIN 10965.
84 KIN 75291.

139 We are satisfied **that Mr Scoular's failure to "grasp the nettle", and to report these matters to Board headquarters, was a systemic failing.** Had he done so then, in our view, his superiors would have had no option but to report the matter to the police. Whatever view might be taken of R 18's allegations against McGrath, we consider that there were clear sexual overtones to these allegations, and the matter should have been reported to the police. Had it been, then at the very least it would have provided a reason to consider the point reached by the Meharg investigation, and reactivate that investigation if necessary. It should also have prompted the Board to consider disciplinary action against Mains for his failure to bring R 18's complaints to the attention of Mr Higham.

The concerns of DC Scully in October 1977

140 DC Scully was the investigating officer for the burglary offences that led to Richard Kerr being brought before the Juvenile Court in October 1977. In the last chapter we recorded that DC Scully spoke to Sgt Sillery of the Juvenile Liaison Branch at Strandtown RUC about his suspicion that there might be some connection of a homosexual nature between Mains and Richard Kerr. DC Scully told Mrs Helen Gogarty, Richard Kerr's social worker, of his suspicions and she told Mr David Morrow, her senior social worker. As a result Mr Morrow went to the next remand hearing and spoke to DC Scully. Mr Morrow and Mrs Gogarty then went to the Purdysburn offices of the Residential & Day Centre management where they discussed DC Scully's concerns with Mr Higham. It will be recalled that Mr Higham was also involved around this time in the discussions with Mrs Hyland, which we have already considered. Although Mr Higham's manuscript note of that meeting was dated 2 October, the Hughes Inquiry explained that date was a mistake, and the meeting probably took place on 21 October, which was the day of Richard Kerr's next court appearance. The note makes it clear that the meeting discussed several matters that might be relevant to the question as to whether there might be a homosexual relationship between Mains and Richard Kerr:

(1) Mains was a friend of R 2, who was a known homosexual.

(2) Mains had shown a preference for Richard Kerr.

(3) There were references to the drinking of sherry, something Richard Kerr had disclosed when explaining his threat to "tell all" about Mains if Mains did not attend the hearings in the Juvenile Court.

(4) Richard Kerr was friends with two middle-aged men, a comment that appears to relate to KIN 340 and KIN 341 who had been with Richard Kerr on the expedition to Larne.

(5) An entry "Mr X/nights" appears to refer to one of these two men.

(6) Other police officers consulted by DC Scully were also of the opinion that Mains was homosexual.

(7) Mr Lindsay Conway, who it will be recalled was the social worker at Rathgael Training School to which Richard Kerr had been remanded by the Juvenile Court, had concerns about the lack of control over the criminal behaviour of Kincora residents such as Stephen Waring.[85]

141 Two further meetings were held to discuss these issues, both taking place on 14 November. The first was at the Purdysburn offices of the Residential & Day Care section and was attended by Mr Scoular, Mrs McGrath, Mr Higham, Mr Morrow and Mr Conway. There was some dispute before the Hughes Inquiry as to what was actually decided at this meeting, but later that day Mr Scoular and Mr Higham went to Strandtown RUC Station where they spoke to Sgt Sillery. Mr Sillery later produced a note which he said was made contemporaneously. This was quoted by the Hughes Inquiry, and it is sufficient to note that it recorded the following points:

(1) Mains was thought by certain CID officers to be homosexual and had been seen in the company of known homosexuals.

(2) It could be inferred that some of the staff at Kincora were homosexual, which would suggest at least one other staff member apart from Mains.

(3) Sgt Sillery had a good opinion of Mains, and was of the view "that if [Mains] was homosexual he would have had the sense not to let his desire take him in the direction of the boys".

(4) Since there had been no allegations for fifteen years (since Kincora came into existence), "the chances are that there was no story to break".

(5) Sgt Sillery had no knowledge of the Cullen/Meharg investigations, and neither it nor the Mason file appear to have been mentioned during the meeting. No doubt if he had been told about either, or

85 KIN 75285.

both, his opinion as to the likelihood of Mains sexually interfering with the residents of Kincora might have been significantly different.

142 The existence of the Mason file and the Cullen/Meharg investigations were of course known to both Mr Scoular and Mr Higham by this stage, and by 14 November Mr Scoular had responded to Mr Higham's memorandum about R 18. Nevertheless it would seem that he did not mention that matter either to Sgt Sillery on that occasion, although the Hughes Inquiry inferred that Mr Scoular did refer to it at a later meeting with Sgt Sillery and DC Scully on 5 December.[86]

143 Although Mr Scoular spoke to Mr Bunting by phone about these matters, the Hughes Inquiry concluded that Mr Scoular did not tell Mr Bunting about Richard Kerr, nor about R 18. We are satisfied that he should have done so. As we have seen, in October he clearly recognised there were important issues about McGrath's behaviour and the failure of Mains to inform Mr Higham about R 18's reference to McGrath's behaviour. Mr Scoular's failure to pass on information relating to Richard Kerr and in relation to R 18 was indefensible. He did institute a daily monitoring report that was to be submitted to Residential & Day Care on a weekly basis, but the Hughes Inquiry concluded this was directed at the disciplinary problems, such as coming in late or getting into trouble with the police, that were a matter of serious concern at the time.[87] We consider that **the failure by Mr Scoular to report the matters relating to R 18 and Richard Kerr to Board Headquarters amounted to a systemic failing.**

January 1978

144 On 11 January 1978 Mrs Hyland telephoned Mr Higham to tell him that R 18 had told her Mains had come in drunk the previous Friday night, wakened him and asked him if anything was wrong. Mr Higham questioned Mains, who denied being inebriated, but he said that R 18 had not been asleep and that he had asked him how R 18 was getting on with McGrath. We consider this matter was properly investigated, and in the absence of any corroborating evidence for R 18's account would not have justified any disciplinary action against Mains.

86 KIN 75289.
87 KIN 75290.

Speculation about Richard Kerr and Kincora by social services staff in 1979

145 When dealing with Richard Kerr's experiences after he was discharged from Borstal in February 1979 in the previous chapter we referred to a memorandum written by Mrs Judith Kennedy. By that time she had succeeded Mrs Helen Gogarty as Kerr's de facto social worker, although he was also the responsibility of the Probation Board because he remained on licence following his discharge from Borstal. We now consider why Mrs Kennedy felt that Kincora was unsuitable for Richard Kerr at that time. She confirmed to the Hughes Inquiry that as Richard Kerr was now nearly eighteen Kincora was the obvious place for him to reside after he left Borstal, but as we have seen in the previous chapter he went to live in Williamson House for several weeks. In her memorandum of 14 March 1979 Mrs Kennedy dealt with the issue of his accommodation in the following passage, which we take from 4.200 of the Hughes Inquiry Report, because part of the original was obliterated for reasons we shall discuss shortly. Relating to accommodation for Richard Kerr, Mrs Kennedy wrote:

> "We all felt he needed a sheltered environment. Kincora Hostel was ruled out because apparently Kincora is under investigation because of the Warden's alleged involvement with a homosexual circle. This investigation has apparently been going on for several years and Kincora is still admitting boys. The indications that [Richard Kerr] has homosexual tendencies are tenuous, indeed (Borstal) reported that throughout his stay there was no sign of homosexual inclinations." (emphasis added)[88]

146 The words underlined in this passage, and the reasons for their inclusion and for the later deletion of them, were examined in great detail by the Hughes Inquiry at 4.200 to 4.213 of their Report, not just for their significance in their own right but as part of a wider examination of what Mrs Kennedy and Mrs Gogarty believed to be the position at Kincora as the result of what they were told by Mr Morrow. That was significant because it was Mrs Kennedy and Mrs Gogarty who approached Mr McKenna through a third party, and his article in the *Irish Independent* of 24 January 1980 was instrumental in the establishment of the Caskey Phase One investigations which resulted in the imprisonment of Mains,

88 KIN 75293.

Semple and McGrath. As well as hearing from Mrs Kennedy and Mrs Gogarty, the Hughes Inquiry heard from Mr Morrow, and other relevant witnesses, and as we agree with the analysis and conclusions of the Hughes Inquiry on this matter, it is sufficient to refer to their findings in general terms.

147 The Hughes Inquiry concluded that the underlined passage represented the views of Mrs Kennedy's superior, Mr Morrow, who saw the hostel as unsatisfactory and suspected (correctly as it turned out) that Richard Kerr was homosexual. Mrs Kennedy told the Hughes Inquiry that Mr Morrow told her that Kincora was under police investigation, and referred to his involvement in a previous case concerning a resident of the Valetta Park Hostel in Newtownards. She told the Sussex Police in 1982 that there was some link between that case and Mains. Mr Morrow accepted to the Hughes Inquiry that he was mistaken in his belief that the boy in the Valetta Park case had been resident in Kincora, and he accepted that the connection between that case and Mains had been pure speculation on his part.[89]

148 Mrs Kennedy's report was considered in its original form by Mr Blair, who was the Principal Social Worker (Fieldwork Services) for the North & West Belfast District which had responsibility for Richard Kerr at that time. Although the exact sequence of events was not clear, Mr Blair queried the underlined passage about Kincora with Mrs Kennedy, and it seems that she accepted that these words should be deleted because it would be unfair to include them as they came from one or two people talking in the office and she did not wish to name them. In fact, Mrs Kennedy's only source was Mr Morrow. Mr Blair then deleted the offending passage from the Report, although the original version remained unaltered in his office. He accepted that Kincora would be an unsuitable placement for Richard Kerr owing to his homosexual susceptibilities and the undesirability of putting him among other young men of his age.[90]

149 Mr Blair had no knowledge of any previous concerns about the Kincora staff, and Mr Morrow had not told Mr Blair about his concerns.[91] We accept that Mr Blair did not make these deletions from Mrs Kennedy's report for any improper reason. He had asked Mrs Kennedy what the basis

89 KIN 75293.
90 KIN 75294.
91 KIN 75295.

for them was, and when she said it was only rumour he understandably concluded that it would be wrong to give the rumours credence by allowing the passage to remain in a document that would inevitably have a fairly wide circulation. However, we agree with the Hughes Inquiry that Mr Blair should have insisted that Mrs Kennedy reveal to him the information she had, and her sources, so that any relevant information could be passed to the East Belfast and Castlereagh Residential and Day Care management and to Board Headquarters if necessary, for their consideration. He should also have contacted the East Belfast & Castlereagh Residential and Care management directly to ask them whether there was any substance in what Mrs Kennedy had said to him, even though after his discussion with her he regarded the references as based on rumour and did not believe that there was anything in it.[92]

150 Had Mr Blair done so, that would have been an additional fragment of information that could have been added to the other rumours and allegations that had come to the attention of the management of East Belfast and Castlereagh Residential and Day Care. We consider **Mr Blair's failure to find out more about the basis of Mrs Kennedy's concerns, and to tell the East Belfast and Castlereagh Residential and Day Care management about them, were systemic failings.**

151 By late 1979 it is clear that Mrs Kennedy and Mrs Gogarty had become concerned that something was amiss with Kincora, that police had investigated it in the past, but despite concerns that Mains was homosexual he remained in charge of Kincora. In December 1979 Mrs Gogarty and Mrs Kennedy met socially and discussed Kincora. As a result they decided to approach the press, and Mrs Gogarty did so through a friend, and this culminated in Mr McKenna's article in the Irish Independent. Their concerns consisted largely of what Mr Morrow said to them. He was their superior, and, as the Hughes Inquiry recorded, he acknowledged to them in evidence that he, "speculated freely about matters for which he had no evidence in fact".[93] The Hughes Inquiry went on to say that because Mrs Gogarty "was an impressionable and inexperienced officer [she] accepted Mr Morrow's speculations at face value and retailed them on that basis". [94]

92 KIN 75295.
93 KIN 75297.
94 KIN 75297.

152 Mrs Gogarty was asked at the Hughes Inquiry what led her to approach a journalist, and she agreed that it was because of the events involving Richard Kerr in the autumn of 1977, which involved the concerns about a relationship between Mains and Richard Kerr, and their feeling in 1979 that although Richard Kerr was no longer in Kincora, "there were other boys there and we both felt that if you had been at risk then other boys were at risk as well".[95] When asked why she did not take her concerns to Mr Gilliland, who was the Director of Social Services, or to Mr Bunting as an Assistant Director of Social Services, she explained, "... I was afraid to do that because I had been told that the decision to remove [Richard Kerr] from Kincora was taken from the very top. I didn't know what that meant".[96] It became clear that Mrs Gogarty felt at the time that Mr Gilliland might have been involved in some way in the decision to prevent Richard Kerr going to Kincora, but she conceded to the Hughes Inquiry that on the basis of her greater experience by that time it would be most unlikely that Mr Gilliland made any recommendation in respect of Richard Kerr.[97]

153 The Hughes Inquiry concluded that Mr Gilliland's involvement was limited to the question of where legal responsibility for Richard Kerr's accommodation rested once he was released from Borstal.[98] It will be recalled from the previous chapter that there was a serious dispute between the Probation Board and the EHSSB about where Richard Kerr should live in the weeks after his release from Borstal and before he was discharged from care. Whilst it is clear Mrs Gogarty and Mrs Kennedy were mistaken when they believed that there was a homosexual connection between Mains and another boy in Kincora as had been suggested by Mr Morrow, or that Richard Kerr had been removed from Kincora for some improper reason, it is likely that their concerns were also influenced by the events of October 1977 when Richard Kerr was committing offences and when DC Scully expressed concerns at that time about the relationship between Mains and Richard Kerr. It is also clear that they were strongly influenced by Mr Morrow's "speculating freely about matters for which he had no evidence in fact". However, despite their mistaken beliefs, it would be wrong to criticise Mrs Kennedy or Mrs Gogarty for taking their concerns to the press. Had they not done so, then it is likely that the highly unsatisfactory way

95 KIN 73274.
96 KIN 73274.
97 KIN 73287.
98 KIN 75294.

the EHSSB had approached concerns brought to it by residents and others about Mains and McGrath would have continued for some time because of the many failings by the Board to properly evaluate the information the Board's employees had received, and after 1971 the repeated failures to pass information to the proper authorities, all of which contributed to the continuation of unchecked sexual abuse of residents of Kincora. We agree with the conclusion of the Hughes Inquiry that Mrs Kennedy and Mrs Gogarty acted with integrity, and their approach was prompted by their genuine concern for the welfare of the children in care, and was crucial in bringing about a long overdue and thorough police investigation of Kincora.

PART EIGHT

Roy Garland and the RUC involvement with Kincora in the 1970s

154 In this chapter, and in the previous chapter, we have referred to suspicions expressed by DC Scully in 1977 about a possible homosexual connection between Mains and Richard Kerr; suspicions that were supported at the time by Sgt Sillery, and which were considered by Mr Scoular and others at that time. Unknown to DC Scully and Sgt Sillery, there had been no fewer than four previous occasions when other RUC officers had been alerted to concerns about Kincora.

(1) An anonymous Robophone message on 23 May 1973.

(2) The meeting between Roy Garland and DC Cullen on 1 March 1974, and DC Cullen's subsequent meetings with ACC Meharg in 1974.

(3) A meeting between Valerie Shaw and D/Supt John Graham in June 1974.

(4) Another meeting between Roy Garland and DC Cullen in January 1976, which led to further contact between DC Cullen and ACC Meharg resulting in DC Cullen's contact with Mr Bunting on 19 February 1976. We have already considered the response of the EHSSB to that meeting, and in the remaining parts of this chapter we examine the response of the RUC to each of these events.

155 Although in chronological sequence the meeting between Valerie Shaw and D/Supt Graham occurred between (2) and (4) above, we shall refer to (2) and (4) as the Cullen/Meharg investigations for the sake of

convenience. It is easier to follow what were in many respects separate events if we examine the Robophone message first, then Valerie Shaw's meeting with D/Supt Graham, followed by the two stages of the Cullen/Meharg investigation. Although these four episodes were distinct in many ways in so far as the RUC were concerned, each had a common link to the actions of Roy Garland. It is therefore appropriate to examine his connection with these matters first because his actions were central to each of them, and that was due to his connections with William McGrath.

Roy Garland

156 Because of his involvement in the matters we are about to consider, the Inquiry invited Roy Garland to be a core participant in the Inquiry, and offered to provide him with legal representation at the Inquiry's expense, subject to his means. He was also requested to provide a witness statement to the Inquiry dealing with questions we considered could assist our work. He declined the offer to become a core participant, and did not provide a witness statement. As will be apparent, the Inquiry obtained a considerable volume of material relating to Roy Garland, and we therefore considered it unnecessary to exercise our power to compel him to provide a witness statement and/or documents, or to give evidence. The correspondence between Roy Garland and the Inquiry about these matters in which he gave his reasons for not co-operating with our Inquiry can be found on the Inquiry website in the Module 15 section at Day 204.

157 On 31 May 2016, Day 204 of the Inquiry's public hearings, the Chairman stated that even though Roy Garland and others had decided not to accept the invitation to be core participants, and had not provided witness statements, the door was still open to them if they wanted to change their minds. He said:

> "If they change their minds and are prepared to provide the witness statements and answer the questions we have posed to them by close of business on Friday 10 June, then we will allow them to take part in the remainder of the Module as core participants. After that it will be too late for the Inquiry to receive, consider, and investigate whatever they wish to say, and to give sufficient time for the other core participants to respond."

158 Roy Garland did not take that opportunity. On 28 September 2016, more than two months after the end of the public hearings into Kincora on 8 July 2016, the Inquiry received a 33-page document signed by Roy Garland, and two additional pages dated 27 September 2016 (whilst the document was dated 26 September on the first page). Despite the disruption to the Inquiry's programme by the provision of this document at such a late stage, despite the fact that Mr Garland did not accept the Inquiry's invitation to become a core participant, and despite his failure to provide a witness statement as requested, the Inquiry has considered and taken into account the contents of all 35 pages of the document.

159 We note that when compiling his document Mr Garland appears to have had access to, and made use of parts of, a lengthy document sent to the Inquiry by Colin Wallace, which the Inquiry received on 12 September 2016. The final section of Mr Garland's document under the heading "Conclusion" is identical to the final section of Colin Wallace's document under the heading "Request to the HIA Inquiry", and it therefore seems that although both had the opportunity to be core participants and to provide statements to the Inquiry, and did not do so, they have been in touch with each other at some stage since. Brian Gemmell also declined to engage with the Inquiry, and Roy Garland's reference in his letter to Brian Gemmell having "recently commented through emails" suggests that he and Brian Gemmell have discussed matters relating to the Inquiry's work.[99] Roy Garland's document has been added to the Inquiry evidence bundle and included in that part of the Inquiry website dealing with Kincora.

160 Roy Garland again wrote to the Inquiry on 14 October 2016, and repeated a number of points he had made before. He also said that he had taken legal advice and is now willing to be interviewed by the Inquiry:

> "....should the Tribunal now feel that the information I have given and concerns I have expressed would best be tested at interview I will be willing to present myself for that purpose"

161 The Inquiry did not invite Roy Garland to be interviewed. Had he engaged with the Inquiry and provided a witness statement as requested almost six months earlier the Inquiry would have called him to give evidence in public during its public hearings. It was no longer possible to do that as

99 KIN 130022.

the last date by statute and the Inquiry's Terms of Reference by which public hearings could be held was 18 July 2016, and the Inquiry was in the final stages of preparing its report in order to submit it by mid January 2017 in accordance with its Terms of Reference. The Inquiry provided Mr Garland with a copy of parts of the draft report and invited him to make any response that he wished. He provided a twenty-two page unsigned response dated 30 November 2016. The Inquiry has nevertheless taken the letter of 14 October 2016 and the response of 30 November 2016 into account when preparing its Report.

162 When considering the weight to be given to the points Mr Garland made in all three documents he submitted to the Inquiry we take into account that by refusing to participate in the Inquiry, submitting these documents some months after the deadline set by the Inquiry, and then making a belated offer to be interviewed he has not fully engaged with the Inquiry as others have done. As a result, the Inquiry has not had the benefit of his oral evidence on matters that the Inquiry considers relevant, as opposed to being presented by him with his views in a manner that prevents his account being examined by the Inquiry in the way that the evidence of those who have come forward and given evidence on oath has been examined. We do not consider it necessary to refer to every point made by Roy Garland in his documents. They will be available on our website and those who wish to do so can consider their contents for themselves.

163 Nevertheless, we wish to make a number of observations about some specific matters he raised. First of all, Roy Garland was not being "accused" of anything by the Inquiry as he has alleged.[100] As our examination of the events relating to McGrath and Kincora shows, Roy Garland was an important figure in those events, and that is why the Inquiry offered him the opportunity to be a core participant. Because he was closely involved in many of the events we have to consider it was necessary for the Inquiry to examine what he did or did not say, or did or did not do. In doing so it was necessary for the Inquiry to refer to many documents relating to him, such as intelligence reports or statements by others. Inquiry counsel made it clear that allegations in such documents should not necessarily be taken as being true; they were referred to in order to see what light, if any, their contents shed on the matters we were investigating.

100 KIN 130024.

164 In the Appendix to his letter he refers to his not attending the Inquiry in the following passage:

> "I did not attend the Historical Institutional Abuse Inquiry (HIA) firstly because the Government did not give the same legal powers to the HIA Inquiry as to the Goddard Inquiry in London – yet both Inquiries were charged with investigating historical child sexual abuse. To me, this seemed wrong as a matter of principle and unfair to the victims in Northern Ireland. Secondly the HIA would not examine Faith House, an evangelical institution that provided William McGrath with opportunities for the abuse of young Christians."[101]

165 Roy Garland had not previously suggested that we investigate Faith House, and in any event it was not within our Terms of Reference. If this was among Roy Garland's reasons for not engaging with the Inquiry he did not put it forward before.

166 We will have occasion to refer to Roy Garland again in the next chapter, but at this stage it is necessary to examine the nature of his relationship with William McGrath in order to explain the actions Roy Garland took, and why he took them, in the 1970s. In doing so it is necessary for us to refer to the sexual aspect of that relationship, because that was inextricably intertwined with the events we will consider and because the reaction of the RUC has to be viewed against the detail of what they were told. The detail is central to an understanding of the RUC response and so it had to be included. We appreciate that Mr Garland found it distressing for these matters to be examined, and we tried to avoid unnecessary detail of the sexual aspect of their relationship as much as possible. However, some details had to be given if a distorted picture of that relationship were not to be created by omitting details that were essential to an understanding of what it was that Roy Garland said, or did not say, or did, or did not do, about McGrath on the occasions we proposed to examine.

167 Roy Garland came from a strongly religious and Protestant background. In one of three articles he wrote for the *Irish Times* in April 1982 he said his father was the associate pastor of a mission on the Shankill Road in Belfast, as well as being a member of an Orange Lodge that only admitted "saved" men. In this context "saved" is generally taken in Northern Ireland to mean that the person has undergone a form of religious experience or conversion leading him or her to dedicate their

101 KIN 130047.

lives to Jesus Christ, irrespective of which Christian denomination, if any, they had been members of. Roy Garland said he was saved at a mission, meaning in this context a religious meeting held in his father's lodge in 1948 when he was aged seven. He described how he came to further dedicate his life to Christ's service at a religious crusade in 1955, and a few months later heard McGrath preach in the mission hall, presumably meaning his father's mission hall. McGrath invited Roy Garland to meet him at Faith House in Finaghy in South Belfast, which Roy Garland did a few months later when he was aged fifteen. He had left school the previous summer aged fourteen. McGrath explained to him on this occasion that Faith House was a "fellowship" where men lived a form of communal life, pooling their wages, "to be used for the salvation of Ireland". McGrath was the full-time secretary of a body known as, "The Christian Fellowship Centre and Irish Emancipation Crusade". The description by Roy Garland of the religious and political beliefs which McGrath expounded to him as a teenager suggests that these were a potent mixture of anti-Catholic Protestant fundamentalism mixed with anti-communism and homosexuality.

168 McGrath evidently became a significant figure in Roy Garland's life in succeeding years, lending him books and suggesting that he attend Bible college. Roy Garland described going to England to a Bible college near Windsor in September 1960, by which time he was presumably nineteen or thereabouts. During his time in Windsor they kept in touch, meeting in London in January 1961 while McGrath was carrying out a religious campaign in mission halls and churches in England. McGrath wrote to Roy Garland on several occasions between 1960 and 1962. Some of these letters survived and Roy Garland gave them to DC Cullen in 1974. In the Irish Times article Roy Garland explained that when his father died in September 1962 McGrath suggested that he should return to Northern Ireland and carry on his father's small business. Roy Garland did not return to the Bible college, and thereafter devoted his efforts to trying to build up the business, as well as delivering religious tracts for McGrath.

The business and political relationship of Roy Garland and William McGrath in the 1960s

169 According to a report compiled by DC Cullen at a later stage of these events, Roy Garland purchased a small business in 1964 on the basis that McGrath would contribute half the purchase price. However,

McGrath did not do so. Whilst DC Cullen recorded that the business did quite well, Roy Garland told him that McGrath had borrowed £2,000 from him and incurred debts in his name. It would seem that during this time McGrath carried on a business selling carpets, but his business ventures do not seem to have been successful, no doubt in part at least due to the amount of time he devoted to his religious and political activities. As we have seen in the previous chapter, before McGrath joined the staff at Kincora in June 1971 he had been working as a counter clerk in a Belfast estate agent's office. By February 1972 the financial relationship between Roy Garland and McGrath had deteriorated to such an extent that Roy Garland obtained a court judgment against McGrath for £1,280.40.[102] In today's values this may not appear a significant amount, but it was a substantial amount at that time, and would be worth more than £16,300 today, (£16,345.60 according to www.thisismoney.co.uk accessed 16 September 2016). It is clear from Roy Garland's Irish Times article of 15 April 1982 that he and McGrath fell out in an extremely acrimonious fashion at that time because of this debt.[103]

170 In the mid-1960s that acrimonious ending to their business relationship lay several years in the future. It is clear that until then the relationship between the two men remained extremely close throughout the latter part of the 1960s, not least because of their shared interest in Northern Ireland politics from a Unionist perspective. As we shall see in greater detail in the next chapter, both were active in one of the many political groupings that emerged on what might be called the Unionist spectrum of political activity in Northern Ireland in the 1960s, an extremely tense period in the history of Northern Ireland.

171 In his *Irish Times* article of 15 April 1982 Roy Garland described how McGrath invited him to become a member of a "Cell", which he described in the article in the following passage:

> "A private ginger group of Orange men chaired by a Church of Ireland minister. Members of District, County and Grand Orange Lodges took part. The objective seemed to be to encourage leadership in Orangeism…In November 1966 the name of the group was changed to [Tara] and McGrath became Chairman".[104]

102 KIN 1684.
103 KIN 55015.
104 KIN 55012.

172 As can be seen from his letter to the Inquiry, it is clear that Roy Garland was politically active in the increasingly volatile and turbulent political and social period in the late 1960s in Northern Ireland. He was the publicity officer of the Young Unionist Council in 1969-1970,[105] and in the Irish Times article of 14 April 1982 described one event of those turbulent times in the following passage:

> "Many loyalists felt under considerable threat during the violence of August 1969 and it is not surprising that McGrath and Paisley were talking about the need for a 'Peoples Militia'. What is surprising is that at the height of this violence McGrath, Paisley, myself and a man called Black from Armagh were talking to the Prime Minister, Major James Chichester-Clark about it. This was during the early hours of Thursday, 14 August, 1969 at Knock RUC Headquarters. We were demanding that the "B" Specials be mobilised and a 'Peoples Militia' be formed."[106]

173 Roy Garland refers to that meeting in his letter to the Inquiry,[107] and it is clear from his letter, and his account of his activities in his *Irish Times* articles, that McGrath and he were close political associates, as can be seen from the preceding passage, and from his description of the development of Tara from a political "ginger group" to a very different organisation. It developed a paramilitary structure with McGrath as commanding officer and Roy Garland as second in command, with "Platoons" led by "Sergeants", who attended central meetings, although Roy Garland said there was little liaison. He said in the same *Irish Times* article:

> "There were said to be weapons stockpiled though I saw none of these. For the most part the objective was to prepare and wait for the appropriate moment when, if the right political leadership existed, Tara could be offered to the Security Forces to work alongside them. I felt that officers should be trained as well. It did not seem right that we should expect men to train to fight without being prepared to use guns ourselves. This idea got little support."[108]

174 Although he did not refer to the UVF in his *Irish Times* articles, in his letter to the Inquiry Roy Garland described how the UVF, a proscribed Loyalist

105 KIN 55011.
106 KIN 55014.
107 KIN 130028.
108 KIN 55013.

terrorist organisation, was closely involved with Tara at that stage:

> "The UVF was an intrinsic part of Tara from its formation in late 1969 until summer/early autumn of 1971 when I left Tara, and the UVF followed shortly afterwards when told of my reasons for leaving."[109]

175 In the third of the *Irish Times* articles on 15 April 1982 Roy Garland said he stopped attending Tara meetings in early August 1971:

> "I knew that this was putting me in an extremely dangerous situation but I felt there was no other course. I visited a man who had been in the Tara group in 1968 but who had left in mysterious circumstances. What he had to say confirmed that I was making the right decision, but it also made me feel very angry and disillusioned. Many Loyalist leaders had known of McGrath's homosexual activities for years and had done little or nothing about them.
>
> I decided that it was my duty to warn young men I had introduced to Tara, to McGrath's prayer meetings and to Ireland's Heritage Lodge. Most of them confirmed my worst fears that McGrath had been attempting to corrupt them, although none of them had, to my knowledge, been corrupted in the sense of becoming homosexuals.
>
> McGrath appeared to be able to exert a strong influence over these young men. I felt that he was using sex to brainwash them into his political ideas."

The reference to "Ireland's Heritage Lodge" was to an Orange lodge with this title founded by McGrath. From Roy Garland's comments it implies that he was himself a member of this lodge.

176 In his letter to the Inquiry he confirmed that he left Tara and the Young Unionists in 1971, saying he also drifted away from the senior Unionist Party and had stopped attending the Free Presbyterian Church. He left the Orange Order a few months later.[110] In these articles Roy Garland described McGrath's views about homosexuality at some length, and in the first of them said that at one point in his discussion with McGrath during his first visit to Faith House in 1955, McGrath had twice touched him on the leg, asking him what this meant; he felt shocked and replied to McGrath that it meant nothing.

177 It can be seen from this necessarily brief summary of Roy Garland's longer descriptions of the relationship between himself and McGrath

109 KIN 130028.
110 KIN 130031.

from 1955, when he was a boy of fifteen, until 1971, when he was thirty or thereabouts, that the relationship between himself and McGrath was extremely close financially, politically and personally for many years until they fell out and Roy Garland distanced himself from McGrath from the summer of 1971 onwards. As we shall see, after McGrath and Roy Garland fell out, Roy Garland spoke to many people expressing his concerns about McGrath.

178 These concerns are only relevant to this Inquiry in so far as he expressed himself anonymously to the police and to social services, and as we shall see in the next chapter to Brian Gemmell, and in person to DC Cullen and to Valerie Shaw. As we have seen and will see, Valerie Shaw conveyed her understanding of them to social services through Mrs Fiddis and Mrs Johnston, and directly to D/Supt Graham. Roy Garland was directly or indirectly the source of all of these contacts, whether they were conveyed anonymously or directly by him, and in the next portion of this chapter we examine what he actually said on these occasions and in what form he conveyed his concerns about McGrath, and McGrath's position in Kincora, to social services and to the police.

179 In chronological terms the first occasion we know of that Roy Garland tried to convey these concerns to social services was when he made the anonymous phone call to the Holywood Road office of the EHSSB, which was received by Colin McKay on 23 January 1974. As we have already noted in our earlier consideration of this episode, the only contemporary record of what was actually said in that anonymous phone call was the third-hand account recorded by Mrs Wilson. This was to the effect that McGrath had made "improper suggestions" to boys in Kincora, including writing a note containing such "improper suggestions" to one of the boys, and had gone to live in Kincora for that purpose. What the "improper suggestions" may actually have been does not appear, but the overall tenor of this note is that the caller was implying that McGrath may have been making homosexual approaches of some sort to the boys in his care at Kincora. It does not seem that an allegation was being made that he had gone further than that and actually sexually abused any boy, and as we shall see on the numerous occasions when Roy Garland conveyed his concerns to others he does not appear to have ever alleged that he knew of any actual sexual offences being committed by McGrath against boys in Kincora, nor has he suggested in his letter to the Inquiry that he knew of offences committed by McGrath

against any residents of Kincora. His concern was that such offences were being committed by McGrath against boys in Kincora, because of Roy Garland's own experiences. We therefore consider it likely that the details of Roy Garland's allegations in the anonymous phone call of 23 January 1974 were as Mrs Wilson recorded them.

180 Roy Garland also expressed his concerns to those directly in authority when he made the Robophone call on 23 May 1973. The Robophone system was a confidential phone line that allowed individuals to bring matters to the attention of the police, and to do so anonymously if they wished. This was a widely used facility and this particular call was numbered 2024 of 1973. In his letter to the Inquiry, Roy Garland criticised the Inquiry for revealing that he made this confidential phone call:

> "However to name me in this way after making a telephone call to a secure line was a breach of my confidentiality. In addition it is wrongly suggested that I am an informer. This is untrue and a dangerous assertion because...There was a serious danger to my life for years and even today this is still possible given that some hard line paramilitaries will be reading these transcripts."[111]

181 This phone call was a very important occasion in the events relating to Kincora, and, as Roy Garland confirmed in his letter, he went to great lengths to alert various individuals, and through them the authorities, to the danger he correctly believed McGrath posed to the residents of Kincora. As he said about Valerie Shaw and Jim McCormick, "almost everything they knew came from me".[112] We make clear in our conclusions that we commend him for his efforts to ensure that police and social services were alerted to the risks posed by McGrath to the boys in Kincora. Were the Inquiry to conceal that Roy Garland made this call, that would be to create an incomplete and significantly misleading account of his actions at that time.

182 In view of the importance of this call we set it out in full:

> "There appears to be a vice ring which is centred in Wm. McGrath, 188 Upper Newtownards Road, who is employed as a Social Worker at Kincora Boys' Hostel, 236 Upper Newtownards Road. McGrath practices various kinds of homosexual perversion, but is known to be indulging in other kinds of perversion as well. He is deeply

111 KIN 130017.
112 KIN 130020.

> involved in underground politics and boys of his are involved in all shades of Unionist Politics, most of these young men would have been involved in perversion with him personally and he is not adverse to pressurising them into adopting policies according to his political objections [sic] which are unknown. He has contact with certain local MPs who are known for their homosexuality and it is thought that this is the lever used to obtain his job as a Social Worker. He has contacts throughout N. Ireland and also in London and beyond. He is constantly in financial difficulty. He leads a secret Militant Organisation known as "Tara", he is widely known among Loyalists and others, but mainly because of the shame and danger attached to exposing him and the repercussions he is allowed to continue. His methods of dealing with boys is to suggest homosexual activities will cure a variety of complaints. McGrath claims the boys are suffering. Once they allow McGrath to get his hands on them they are wide open to exploitation, sexually, politically and financially."[113]

183 Whilst the record is a précis of the call, and therefore not a verbatim transcript of what was said, it is clear from the references to McGrath working in Kincora at number 236, and living at 188, Upper Newtownards Road that Roy Garland knew where McGrath was working and living by this time. As the author of the call, Roy Garland also refers at length to McGrath's membership of Tara and to his political activities. He also alleged that there appeared to be a vice ring centred on McGrath, and that, "boys of [McGrath's] are involved in all shades of Unionist Politics". Whilst the reference to "boys" on its own would be capable of being interpreted as referring to residents at Kincora, the expression is clearly qualified by the reference to them being involved in politics. This qualification might suggest that the people concerned are adults, as indeed the following words make clear when the anonymous caller is recorded as saying that "most of these young men would have been involved in perversion with him personally". (emphasis added) As we shall see, these allegations echo what Roy Garland was to say to others subsequently.

184 The anonymous call was received at RUC Headquarters at 3:05pm on 23 May 1973, and forwarded to the Divisional Commander at E Division the next day with the instruction:

> "Please cause this information to be investigated and report successful results".

113 KIN 30343.

E Division at RUC Mountpottinger was the headquarters for the area including Kincora, and as Kincora lay within the sub-division at Strandtown RUC the Divisional Commander sent the message through his chain of command to that station.

185 Ultimately Constable Long of Strandtown was instructed to investigate. Constable Long was not a detective but a uniformed officer. He visited Kincora on 4 June 1973 and spoke to Mains about the allegations. From his report it does not seem that he confronted McGrath with the allegations. By this time it is probable that McGrath had already started to sexually approach boys in Kincora. As we explained in the previous chapter, HIA 532 who entered Kincora for the first time in April 1972, later described to the police how McGrath attempted to masturbate him when he woke HIA 532 in the mornings. It is therefore probable that McGrath had done this to him before Constable Long came to Kincora on 4 June 1973. Of the four former residents who were in Kincora by 4 June 1973 and who later alleged McGrath made sexual approaches to them, only R 10, who arrived on 23 March 1973, and HIA 145, who arrived on 30 April 1973, definitely dated their experiences of abuse as happening before 4 June. Their experiences were similar to those of HIA 532, as R 10 awoke to find McGrath fondling his genitals, and HIA 145 awoke to find McGrath fondling his inner thigh. It would therefore seem that by the date of Constable Long's visit, McGrath's approaches to the residents had not progressed to the severity they did later. It is also relevant to recall that by June 1973 Mains and Semple were no longer engaging in sexual activity with boys in Kincora, although as we have seen they had done so in the past before McGrath arrived.

186 Because the investigations into Mains's behaviour in 1967 and 1971 had never been referred to the police, the uniformed police at Mountpottinger and Strandtown had no reason to suspect that Mains had been engaged in sexual behaviour when Constable Long spoke to him on 4 June 1973. He told Mains about the telephone allegations, and Mains said that he was unaware of any "perversion" going on, and if there was he would be sure to know of it. Mains clearly knew something of McGrath's previous financial difficulties because he told Constable Long that McGrath had lost £2,000 in the carpet business. He described McGrath as a very decent type of chap of deep religious convictions who was high up in the Orange Order. He said that he had no idea who might have passed on this information over the phone, and he was satisfied the information came from a crank, and was convinced

no one at the hostel would be capable of this, presumably meaning no one at the hostel made the call.

187 It is unclear whether anything relating to McGrath had come to the attention of Mains by then, and so it may be that Mains's response to these allegations was accurate within his knowledge at that time so far as McGrath was concerned. Of course Mains was lying when he said he was unaware of any perversions at Kincora, because he had engaged in such behaviour with several boys in the past, and his homosexual relationship with R 2 was continuing during R 2's overnight visits to Kincora. Mains also knew about Semple's behaviour in the past, but no doubt felt a considerable degree of relief as it appeared Constable Long was only making enquiries about McGrath, and that there were no allegations relating to either Semple or himself. Constable Long reported his enquiries to his inspector, who duly reported up the chain of command back to the Divisional Commander, and none of the superior officers through whose hands the report progressed suggested that any further action should be taken.

188 The Robophone message did not specifically allege that homosexual offences were being perpetrated in Kincora, although, as we have seen, it referred to "boys". However, its tenor plainly related to McGrath's homosexual activity with "young men" who were his political associates. We are satisfied that the RUC should have gone further and contacted the EHSSB at a higher level than Mains, as was eventually done by DC Cullen when he spoke to Robert Bunting in 1976. It has to be remembered in this context that 1973 was the most violent year of the entire period of violence in Northern Ireland, during which there were 250 deaths, 2,651 injuries, as well as huge numbers of shootings, bombings and other forms of terrorist violence.[114] The intensity of the violence placed a great strain on the RUC at the time, and in addition there was not then the practice of sharing information and having a multi-agency approach to investigating abuse.

189 This was an anonymous report with no specific allegations about Kincora as opposed to those about McGrath. Despite the limitations of any anonymous allegation and the pressures on the police at this time **we consider that the failure of the RUC to approach the EHSSB at a higher level than Mains was a systemic failing on the part of the police in the**

114 Cmnd 7009, the Standing Advisory Commission on Human Rights' Report The Protection of Human Rights by Law in Northern Ireland, p.6.

RUC division to whom the anonymous call was referred for investigation. We have not so far referred to the information held by RUC Special Branch on McGrath by this time and we shall do so in the next chapter.

Valerie Shaw and D/Supt John Graham

190 Miss Shaw explained to the Sussex police in 1982 that a Mrs Greenwood told her that she had been told by a Mr McCormick of the activities of a man in the Orange Order, in Christian circles and in political circles who was a homosexual, who had used his position to corrupt or attempt to corrupt young men and boys into homosexual practices and who was extending his activities into the Free Presbyterian Church. Miss Shaw had been a member of that church for many years and was concerned about this. She spoke to Mr McCormick on a number of occasions, and he ultimately told her that the man was McGrath and that his information came from Roy Garland. She then approached Roy Garland. She said that he told her about Faith House in Finaghy, about McGrath's political views, that McGrath was homosexual and that he was employed in a boys' home called Kincora. It would appear from her 1982 statement that Roy Garland did not explain to her why he thought McGrath was homosexual. She then approached Dr Ian Paisley MP who was also the Moderator of the Free Presbyterian Church and Minister of the Martyrs Memorial Church where she worked at the time. She claimed she spoke to Dr Paisley about her concerns on at least seven occasions, but he disputed this. Be that as it may, and as we have already explained we are not concerned with what others apart from the police and social services did or did not know, Miss Shaw failed to make progress in that way and mentioned her concerns about McGrath to others. Although it is not entirely clear how the contact came to be brought about, there is no doubt that she spoke to D/Supt Graham not long before he retired from the RUC on 30 June 1974.

191 At that time he was head of the CID in Belfast. It would seem from what D/Ch/Supt Clarke told the Inquiry that in that capacity he did not report to ACC Meharg, to whom we shall refer again shortly, but was responsible to the ACC for Belfast. D/Supt Graham did not give oral evidence to the Hughes Inquiry, unlike Valerie Shaw, although he did respond in writing to a request for information from that Inquiry. He did give a statement to the RUC in 1980 and to the Sussex Police in 1982. Mr Graham is now dead. From his statement to the Sussex Police,

and from Valerie Shaw's accounts, it is clear that they met in his car and spoke about McGrath for some time. She told him McGrath was homosexual, was employed in Kincora and that she was concerned by that. He told her the police would need to obtain evidence, and that one way of obtaining that evidence would be to maintain observation on Kincora or on McGrath's house. She said that she mentioned Roy Garland's name during that conversation[115] although Mr Graham, as he was by that time, did not refer to Mr Garland, either in his RUC statement in 1980[116] or in his 1982 statement to the Sussex Police.[117] As it is common ground that there was a reference to the need for surveillance, it may be that Roy Garland's name was not mentioned, because that would have been a crucially important piece of information. However, whether Roy Garland's name was mentioned or not, D/Supt Graham accepted that he was concerned about what he was told, and he said that he reported the matter to the CID at Mountpottinger RUC Station.

192 No trace of any such report by him was found. In the subsequent RUC investigation in 1980, and in the Sussex Police investigation in 1982, the relevant CID officers in Mountpottinger denied ever receiving any report, either oral or written, from D/Supt Graham. In the event, if he did make such a report the matter was never followed up, and so nothing came of this initiative by Miss Shaw who had attempted to bring her concerns, supported as they were by what Roy Garland had told her, to the attention of the RUC at a high level. As in the Robophone call in 1973, there is nothing to suggest that Roy Garland revealed to Miss Shaw his own experiences with McGrath in the past. Her concerns reflected his stated concern that McGrath was homosexual, had corrupted young men or boys in the past, and because of that past corruption it was believed that he now posed a risk to the boys in the hostel. However, on the face of it that risk was being represented as a possibility, because it was not an allegation that McGrath was believed to have committed a sexual offence on any resident of Kincora.

193 So far as D/Supt Graham was aware at the time, he was the highest ranking police officer to whom these concerns had been expressed. He knew nothing of either the anonymous phone call made by Roy Garland in 1973, nor Roy Garland's discussions not long before with DC Cullen,

115 KIN 40713.
116 KIN 10795.
117 KIN 40718.

discussions which resulted in the Cullen/Meharg investigation which had started earlier in 1974. D/Supt Graham's own accounts leave no reason for doubt that he accepted what Miss Shaw told him, and on the basis of that concluded that the matter needed to be pursued. He said he gave instructions to that effect to Mountpottinger CID. However, nothing was done, and the PSNI concede that D/Supt Graham's response to what Miss Shaw told him amounted to a significant personal failing and neglect of duty on his part.[118] We are satisfied that was the case for the following reasons:

(1) D/Supt Graham was an extremely experienced and very senior detective, yet he failed to keep any record of his meeting with Miss Shaw or what she told him, or of his subsequent actions.

(2) He clearly recognised that these were allegations of possible homosexuality, child abuse and paramilitary involvement all relating to McGrath, yet he failed to take adequate steps to launch an investigation by him giving a formal instruction to one of his CID subordinates to institute an immediate police investigation.

(3) An oral instruction was not enough. It would not have been difficult for him to give a brief written instruction to the D/Ch Inspector in Mountpottinger, supporting this with a brief statement of what Miss Shaw had told him and where she could be contacted. Such written instructions need not have been very detailed and could have been supplemented by a more detailed oral briefing of the officer or officers instructed to carry out the investigation.

(4) Having failed to take these steps, he then failed to follow the matter up or ensure that instructions were left for his successor so that his successor could be informed and could take the matter up. D/Ch/Supt Clarke said in his statement to the Inquiry that the failure of D/Supt Graham to do anything with the information he received from Valerie Shaw was inexplicable.[119] In his evidence to the Inquiry in Day 219 at page 154 he summarised the failings of the D/Supt when he said that the D/Supt "makes no provision and takes no steps to ensure that it [Miss Shaw's allegation] is dealt with…and I don't think as a senior detective that is the level of professional drive or vigour I would expect".

118 KIN 1854.
119 KIN 1854.

194 The steps which should have been taken by D/Supt Graham were simple and elementary. We consider a possible reason why he did not show the necessary drive or vigour was because D/Supt Graham was due to retire from a very demanding post in a few weeks time, and for whatever reason did not give the matter the attention it deserved. Had these elementary steps been taken to institute a proper investigation by trained detectives, such an investigation should at least have discovered the record of the 1973 anonymous call. Whether such an investigation, even with that added information conveyed by the 1973 call, would have led the investigating police to contact the EHSSB at a higher level is speculative. Had they done so, those officers would have been provided with the Mason file and learnt for the first time of the 1967 and 1971 allegations against Mains. **The failure to take these steps amounted to systemic failings.**

The Cullen/Meharg investigation in 1974

195 We now turn to consider the events of 1973 and 1974 which resulted in DC Cullen of the RUC Drug Squad at Belfast Donegall Pass RUC Station informing ACC Meharg, the head of "Crime" Branch of the RUC between 1971 and 1981, of what he had been told by Roy Garland, which resulted in what has been called the Cullen/Meharg investigation. As we explained in an earlier chapter, the Cullen/Meharg investigation had a second stage in 1976. ACC Meharg died in 2011. Mr Cullen, who retired from the RUC in 1988 after 30 years service, was still alive during our public hearings, but unfortunately his mental condition was such that he was unable to assist the Inquiry. Sadly he died in September 2016. Both gave oral evidence to the Hughes Inquiry, and were cross examined about what they said to each other, and what each did, or did not, do. Whilst there was considerable common ground in their accounts, there were also disagreements about a number of matters. Whilst we have the transcripts of their evidence, the Hughes Inquiry had the advantage of reaching its views having seen and heard both witnesses.

196 Before we consider the Cullen/Meharg investigation we wish to make it clear that the only reason the Inquiry was concerned with whatever happened between Roy Garland and McGrath of a sexual nature was because what happened was the most important aspect of the material that became known to DC Cullen. The Inquiry had to investigate these matters in order to establish as far as possible what information was

conveyed to DC Cullen, because the nature and extent of that information led to the Cullen/Meharg investigation, and in order to establish how that investigation came about, and was conducted, the Inquiry had to examine these matters.

197 Contrary to Roy Garland's assertion in his letter, the Inquiry has sought to understand why McGrath's activity was not stopped at an earlier stage.[120] As part of that process, the Inquiry had to examine in detail what Roy Garland did, or did not, say to the police. In his letter to the Inquiry Roy Garland emphasised that he was not homosexual at any stage:

> "It is misleading to suggest I was involved in homosexual activity…I was not and never was at any stage homosexual. I was abused in a limited way and one that was neither continuous nor prolonged as has been suggested because I rejected it. William McGrath tried desperately to convince me that relations between males were normal…In truth he was deeply attracted to young boys and men. I was never attracted to homosexuality, which greatly annoyed him."[121]

198 The Inquiry does not suggest that Roy Garland was a homosexual or was attracted to homosexual activity, but it is clear from what Roy Garland said to the Sussex Police in 1982 that McGrath engaged in sexual acts involving him on more than one occasion over a number of years. He said to the Inquiry in his letter:

> "As far as I was concerned the attempts were infrequent and lasted for relatively few years…I rejected McGrath's approaches, which were usually minor and not necessarily homosexual".[122]

In his Response to the Inquiry of 30 November 2016 he was rather more specific as to how long this lasted, saying:

> "The abuse, such as it was, had stopped at an early stage in the early 1960s"[123]

The relevance of these matters to the Inquiry is the light they shed on McGrath's actions, and what the RUC learnt about them, because the extent of McGrath's behaviour is crucial to any examination of what led to the Cullen/Meharg investigation, and how that investigation should have been conducted.

120 KIN 130025.
121 KIN 130025.
122 KIN 130042.
123 KIN 130058.

199 Roy Garland said in his letter to our Inquiry that while he agreed to appear at the Hughes Inquiry he was not invited.[124] He was not called to give evidence to the Hughes Inquiry, something that caused considerable controversy at that Inquiry. He was asked to provide our Inquiry with a written statement addressing a number of questions posed to him by the Inquiry, but declined to do so. In his letter to the Inquiry Roy Garland refers to two matters he was asked to address by the Inquiry in a witness statement,[125] although, as can be seen from the correspondence between him and the Inquiry at Day 204, the Inquiry posed several other questions as well. Whilst Roy Garland spoke to the RUC in March 1980 during the Caskey Phase One investigation he was not willing to make a written statement at that time. He did make two statements to the Sussex police in 1982. There are a number of areas where we are dependent upon notes made at various times by DC Cullen when we seek to establish exactly what Roy Garland did tell DC Cullen about the extent and nature of the relationship between himself and McGrath, compared to more limited accounts Roy Garland gave on various occasions in the past. Roy Garland has since given some further information about what he did, or did not, say to DC Cullen in his letter to the Inquiry, and we consider what Roy Garland said in his letter to our Inquiry in due course.

200 By late 1973 DC Cullen had almost fifteen years service in the RUC. Since 1970 he had been attached to the Drugs Squad, which was based in Donegall Pass RUC Station, and he was a part-time dog handler with the drug squad. Although he was a DC it seems that he had little or no formal detective training until he went on the Hendon CID Initial Training Course between 3 December 1973 and 9 February 1974.[126] His contact with Roy Garland came about as a result of a meeting DC Cullen had with William McCormick in November 1973. We have already referred to Mr McCormick and will have occasion to do so again in the next chapter. Mr McCormick was a veterinary surgeon who lived on the outskirts of Belfast in Carryduff, County Down, although he told the Sussex Police in 1982 that he considered his vocation to be that of a Christian evangelist.[127] In that capacity he provided counselling for a number of people of all ages who came to him for advice on a wide variety of matters. One of these was Mrs Greenwood, to whom

124 KIN 130024.
125 KIN 130017.
126 KIN 72124 and 40113.
127 KIN 40702 and KIN 721123.

reference has already been made. It would seem that he told her about McGrath, and as we have already explained it was Mrs Greenwood who then told Valerie Shaw about McGrath. As we shall see in the next chapter, Brian Gemmell was also in contact with Mr McCormick, and through him with Roy Garland. Mr McCormick died in August 1989.

201 It would appear from what Mr McCormick told the Sussex Police that his knowledge of McGrath's activities came from Roy Garland who spoke to Mr McCormick shortly before the events we are about to examine, which would suggest that it was sometime not long before November 1973 that Roy Garland told Mr McCormick of his concerns about McGrath.[128] In his statement of 10 March 1982 to the Sussex Police Mr McCormick recounted that Roy Garland explained McGrath's seduction technique in the following way:

> "...McGrath operated by having Garland arranging for boys to see him individually. McGrath after telling the boy of his potential would then convince him that he had an emotional block. He would demonstrate by inviting the boy to touch his private parts and then use the refusal as evidence of the block. McGrath would then suggest that the boy needed liberating and in that manner induce them into homosexual acts. Garland said he had arranged for some twenty boys to be seen by McGrath for this purpose during the 60s."[129]

202 It is clear from the following quotation from his letter to the Inquiry that Roy Garland denies saying any of these things to Mr McCormick, and does not believe Mr McCormick said them:

> "I never said any of this and it did not happen. Neither do I believe Jim McCormick made such a hurtful and disgusting suggestion."

203 He also said that Brian Gemmell had written to him that:

> "I am certain Jim McC would never have said such a thing. He was a man concerned with the truth and would not have made up things or embellished a story".[130]

204 It is clear that Mr McCormick did say these things in his police statement, and far from being "an obscure document" as Roy Garland described it, this was a statement which the maker said was true and acknowledged could render him liable to prosecution if he had "wilfully stated anything

128 KIN 40702.
129 KIN 40702.
130 KIN 130022.

in it which I know to be false or do not believe to be true". We see no reason to believe that Mr McCormick made up his account of what he said Roy Garland said to him, or embellished the truth. The reference by Mr McCormick to being told that about twenty boys had been introduced to McGrath by Roy Garland, and by implication the suggestion that some of them at least may have become involved in homosexual acts with McGrath, accords with Roy Garland's reference in his *Irish Times* article of 15 April 1982 to his having warned young men he had introduced to Tara, and McGrath, although he said, "none of them had, to my knowledge, been corrupted in the sense of becoming homosexuals".[131]

205 DC Cullen explained to the Hughes Inquiry that at this time a lot of allegations about the occult were emerging in the drug scene, and he had been given Mr McCormick's name as someone who had knowledge of the occult and exorcism. He asked for an appointment with Mr McCormick to see if he could gain any information that would be of assistance to the police.[132] The meeting took place in November 1973. Roy Garland was not present at that meeting, but Mr McCormick told DC Cullen the information that Roy Garland had given to him about McGrath, presumably because Mr McCormick felt this was information which should be passed on to the police. DC Cullen did not pursue the matter at that time, but after he returned from his Hendon CID course in February 1974 he thought about what he had been told. He decided that he would contact Mr McCormick again to see if Mr McCormick would put him in contact with the person who had given the information about McGrath, "to see if there was any substance in it", as he put it to the Hughes Inquiry.[133] A meeting was arranged with Roy Garland, and it took place in Mr McCormick's house on 1 March 1974.

206 DC Cullen was accompanied by DC Duff, a colleague from the Drug Squad at Donegall Pass. DC Cullen explained to the Hughes Inquiry that Roy Garland had been very reluctant to speak to the police at all, and had to be persuaded to come to speak to him. By now Roy Garland was in his early thirties, married with children, and a mature student at Queen's University.[134] It would appear that he explained his relationship with McGrath to DC Cullen in some detail, saying it ceased when they parted company because of a business dispute. DC Cullen told the Hughes Inquiry that Roy Garland told him that McGrath:

131 KIN 55015.
132 KIN 72187 and KIN 72188.
133 KIN 72124.
134 KIN 72130.

> "...had interfered with him as a teenager, homosexually, and these meetings took place as a result of attending religious meetings and other organisations"

in the early 1960s.[135]

207 It would seem that Roy Garland never made any allegations that there had been any incidents in Kincora, or related to anyone who was at Kincora, either at that meeting or at any stage of his lengthy involvement with DC Cullen.[136]

208 DC Cullen explained to the Hughes Inquiry that Roy Garland was, "very concerned about his family, his children, and the stigma that would be attached to any investigation to which his name would be attached."[137] He was also concerned for his safety because he believed McGrath, "had some association with subversives".[138]

209 Roy Garland said in his letter to the Inquiry that he believed he was not asked if he was prepared to be a witness if necessary:

> "I was never to the best of my knowledge asked, 'to step forward'...I am quite confident that I was not asked to 'step forward'".[139]
>
> "To the best of my knowledge I was never asked by DC Cullen to make a statement. I probably would have given him one if asked even though this would have been very risky."[140]

210 DC Cullen also told the Hughes Inquiry that Roy Garland was reluctant to give evidence:

> "...at that stage he wasn't prepared to come out into the open and give evidence, that's where the difficulty arose. If he had been prepared to give evidence I think a different situation would have arisen...because we had a witness then who could have given evidence about Mr McGrath's homosexual behaviour."[141]

211 All the evidence of Roy Garland's actions in the 1970s shows that whilst he was making considerable efforts to draw the attention of social services and the police to McGrath, on every other occasion he did so in a way that would not require him to be publicly identified, as when he

135 KIN 72124.
136 KIN 72126.
137 KIN 72138.
138 KIN 72130.
139 KIN 130036.
140 KIN 130041.
141 KIN 72202.

spoke to Valerie Shaw and Jim McCormick, or made anonymous phone calls to the police and social services. We prefer DC Cullen's evidence on oath to the Hughes Inquiry that Roy Garland was not willing to be a witness in 1974, supported as it is by Roy Garland's unwillingness to make a formal witness statement to DS Elliott in 1980.

212 It is clear that at that first meeting DC Cullen had reservations about some of the things that he was being told. He said to the Hughes Inquiry that some of the background associations and activities of McGrath, "sounded a bit bizarre, something that you would read in a novel somewhere",[142] and, he had to keep:

> "an open mind because [Garland] had run afoul of Mr McGrath in the past, ...there were court proceedings in relation to money and things. I had to keep an open mind in the whole situation".[143]

He said:

> "... I wasn't sure, even at that time, if his allegations were meant to hurt Mr McGrath and cause him some more problems out of spite, or whether the facts were true. That is why I sought advice; that is why I furthered my Inquiries in relation to the information and tried to do a bit more ground work on it." [144]

213 DC Cullen said there were a number of other matters that caused him concern, namely, "the involvement in paramilitary activities and alleged homosexuality", and he was also concerned about Roy Garland's safety or security, and that of his immediate family, "because of his association with McGrath".[145]

214 The next day, 2 March 1974, DC Cullen requested and was given a meeting with ACC Meharg at RUC Headquarters. It is one of several unsatisfactory features of the Cullen/Meharg investigation that no notes seem to have been made of any of his meetings at the time by DC Cullen, whether with Roy Garland or ACC Meharg. Nor were any notes made, or written directions given, by ACC Meharg. There are a number of typewritten documents which appear to have been prepared by DC Cullen at various stages, as well as what seemed to be hand-written drafts of the typewritten documents, but it is not easy to establish exactly when all were written, or in what sequence. DC Cullen produced

142 KIN 72132.
143 KIN 72139.
144 KIN 72139.
145 KIN 72132.

these, and later documents dated 1980, during subsequent police investigations. The contents of the 1980 document suggest that some parts were taken from the earlier documents, whilst other information was added later. The origins of these typed and hand-written documents were explained by DC Cullen during his evidence to the Hughes Inquiry, but what he told ACC Meharg, and what ACC Meharg said to him, on 2 March and on later occasions was disputed.

215 In those circumstances we do not intend to seek to reconcile any discrepancies between the various documents; rather we examine what we regard as the salient matters that occurred during the 1974 stage of the Cullen/Meharg investigation. What followed was by any showing an extraordinary and inept series of events, and to describe them as an "investigation" is to imply that whatever took place followed a systematic and conventional course whereas, as we shall see, what transpired was neither conventional nor systematic, nor was it competently organised or executed.

216 The typewritten document later referred to as DBE 16 was addressed to ACC Meharg and refers to the meeting on 2 March 1974 in the first paragraph. This document was plainly compiled by DC Cullen and is dated 21 March 1974. In it he refers to their meeting of 2 March 1974, but does not say in any detail what was said to him at that meeting. For that, we are dependent on his evidence and that of ACC Meharg to the Hughes Inquiry, which is reviewed at 4.102 and subsequent passages of their Report.

217 It would seem that there was at least one further meeting between DC Cullen and Roy Garland after the meeting of 1 March 1974 at which Roy Garland gave him a number of letters that he had received from McGrath in the early 1960s. He appears to have done so to support his allegation that McGrath was homosexual. In his response of 30 November 2016 to the Inquiry Roy Garland confirmed that there were more meetings, saying "most were informal and took place in the street".[146] When that second meeting took place is not known, nor is the date of a second meeting between DC Cullen and ACC Meharg at which ACC Meharg was given the letters. He read them and returned them later to DC Cullen, which would suggest that there may have been a further, third meeting between himself and DC Cullen

146 KIN 130061.

218 Although the DBE 16 document is dated 21 March 1974, its contents do not throw any light on when the other meetings occurred between DC Cullen and ACC Meharg, or between DC Cullen and Roy Garland. The DBE 16 document may only have been a draft, because there are several blank spaces in its 23 paragraphs which appear to have been left to enable names and other relevant personal details of identifiable individuals to be inserted later.[147] JC 2 is a hand-written document also dated 21 March 1974 and is almost identical to the typed document DBE 16, except it contains three extra numbered and typed paragraphs.[148] JC 2 is undated, and bears the handwritten inscription, "Intelligence Log William McGrath". The typed first paragraph referring to the meeting of 2 March 1974 of ACC Meharg and DC Cullen has been replaced by a hand-written first paragraph, "Intelligence of an unconfirmed nature relating to William McGrath, 50/60 years, 188 Upper N'Ards Road, Belfast, and other people who have associated in some measure with subject".[149] These alterations suggest that DC Cullen adapted the DBE 16 document to produce a second related, and largely identical, document, in the form of an "Intelligence Log" intended for ACC Meharg.

219 JC 3 was a third document and was hand written. It was undated, and followed the text and layout of DBE 16 up to paragraph 23. It also contained the three numbered paragraphs 24, 25 and 26 to be found in JC 3, but is a significantly longer document. It runs to 54 numbered paragraphs with a great deal of additional information about McGrath's political activities, his associates and his sexual proclivities. It is noteworthy that the references to McGrath's sexual proclivities are more detailed than in the other two documents, although the reference to a sexual device in paragraph 14 of JC 2 does not appear in Paragraph 14 of JC 3, or for that matter in paragraph 14 of DBE 16. JC 3 also refers to pornography held in a locked filing cabinet accessible only to McGrath. It also includes a reference to Roy Garland being asked by McGrath to write letters to girls about sexual matters.[150]

220 DC Cullen's evidence to the Hughes Inquiry was that all the information he received had been gathered by him by July 1974, when his enquiries lapsed after he received no further instructions from ACC Meharg.[151]

147 KIN 114098-114100.
148 KIN 114068.
149 KIN 114066.
150 KIN 114069 to 114083.
151 KIN 75270.

Apart from the letters he had given to ACC Meharg, DC Cullen was unable to say to the Hughes Inquiry that all these documents had been shown to ACC Meharg, but he said the information contained in them was made known to the ACC. Crucially, he maintained he told ACC Meharg that McGrath had attempted to touch Roy Garland's genitals when the latter was a teenager.

221 ACC Meharg accepted he was told that Roy Garland alleged that McGrath was homosexual, worked in Kincora, was possibly connected with paramilitary activities, and that he had read the letters given to him. He was not satisfied that the letters were of a homosexual nature. However, he said he was told by DC Cullen that no homosexual acts had taken place between McGrath and Roy Garland, saying that if he had been told he would have had no hesitation in having the matter fully investigated.[152]

222 The Hughes Inquiry did not refer expressly to this conflict between ACC Meharg and DC Cullen, saying only that, "we accept that all of the information contained in the documents produced by DC Cullen was available to him in 1974, and these included allegations that McGrath had been involved in homosexual activity with young men some considerable number of years previously".[153]

223 In his letter to the Inquiry Roy Garland denied saying things that are recorded in these notes, stating that they "are so ridiculous they should have been laughed out of court".[154] We note that some of the details were recounted by Roy Garland to DS Elliott on 6 March 1980 in the interview referred to below, when Roy Garland said McGrath kept vibrators and the like at his house in a locker with drawers.[155]

224 Roy Garland also referred in his letter to introducing DC Cullen to a "young victim who talked freely about being seriously abused".[156] However, DC Cullen never suggested to the Hughes Inquiry that he received information from anyone other than Roy Garland. So far as we are aware, Roy Garland's statement that he introduced another victim to DC Cullen, someone who might therefore have provided some or all of the evidence of abuse recorded by DC Cullen, has never been made before, and as we explain below none of the material we have examined supports Roy Garland's assertion that he introduced such a person to DC Cullen.

152 KIN 75271.
153 KIN 75271.
154 KIN 130018.
155 KIN 12192.
156 KIN 130036.

225 Roy Garland was interviewed by DS Elliott of the RUC on 6 March 1980, and DS Elliott makes no reference to such a person in his witness statement.[157] DS Elliott later prepared a seven-page resumé of that meeting of 6 March in preparation for McGrath's interview by the RUC on 1 April 1980. Whilst the resumé refers to "a source" who wishes to remain anonymous it is clear from the reference to 6 March, and from the detail in the document, that the source was Roy Garland. There is no reference to Roy Garland mentioning another potential witness in the resumé.[158]

226 Roy Garland did not refer to any such individual in his statement to the Sussex Police in 1982.[159] DC Cullen's references in these documents to "my informant" when giving details that clearly came from Roy Garland, such as the details of Roy Garland's business and financial relationship with McGrath,[160] support his evidence to the Hughes Inquiry that the information he passed to ACC Meharg came from Informant B, that is from Roy Garland.

227 Mr McCormick did not refer to any other person being present at Roy Garland's meetings with DC Cullen, which Mr McCormick also attended, in his 1982 Sussex Police statement to which we referred earlier, nor did he do so in his 1980 statement to the RUC.[161] In his response to the Inquiry of 30 November 2016 Roy Garland made a number of references to a meeting between "a young man and DC Cullen", and pointed to his reference to introducing a twenty-year-old friend to DC Cullen in his statement to the Sussex Police. However, the only reference to such a person being introduced to DC Cullen comes from Roy Garland, and is not supported by any other evidence, nor has any such person ever come forward.

228 These details were of crucial importance to establishing what DC Cullen told ACC Meharg, because the details were fundamental to any decision by the police to start an investigation into what Roy Garland had told the police. A single episode when McGrath was alleged to have put his hand on Garland's leg many years before was unlikely to have been considered something worthy of a police investigation. An allegation of sexual activity between males that occurred on more than one occasion was a very different matter. We are satisfied ACC Meharg did ask DC Cullen what the extent of any contact had been for that reason, and so

157 KIN 10762.
158 KIN 12188-12194.
159 KIN 40688 to 40691.
160 KIN 114066 and 114067.
161 KIN 10761.

the account of that sexual activity recorded at the time by DC Cullen, which Roy Garland disputes, would have been a very important area to be explored by DC Cullen with Roy Garland at the time.

229 Whilst we took into account Roy Garland's denials that he said these things attributed to him by DC Cullen, from the material we have examined we saw no reason to conclude that DC Cullen made up, misunderstood or distorted what he recorded at the time as coming from Roy Garland.

230 We have very carefully considered the conflict between the recollections of ACC Meharg and DC Cullen as to whether the latter told the former that homosexual acts had occurred between Roy Garland and McGrath in the 1960s. Although Roy Garland had not said so expressly, and his accounts in his *Irish Times* article of 13 April 1982 said only that McGrath touched him on the leg,[162] he gave a different account to the Sussex Police of McGrath's approach to him during their first meeting in Faith House. In his Sussex Police statement of 1982 he said that after McGrath touched him on the leg McGrath then opened, "the front of my trousers and touched my private parts", adding that McGrath, "continued to make this type of approach to me throughout my teens until I went to the All Nations Bible College, Maidenhead, in 1962".[163]

231 We are satisfied the detail given in the 1974 documents of McGrath's sexual activity with Roy Garland could only have come from Roy Garland and is consistent with what Roy Garland told the Sussex Police in 1982, although the account in the 1974 documents was more detailed and explicit. A single act of touching of the leg would not have been sufficient to justify any discussion with, let alone an approach to, an ACC. Any discussion between ACC Meharg and DC Cullen would, in our opinion, have inevitably included the key question as to whether any explicitly homosexual acts had occurred between McGrath and Roy Garland. We consider it probable that DC Cullen did tell ACC Meharg that actual homosexual contact had taken place between McGrath and Roy Garland.

232 The 1974 documents show that DC Cullen accumulated considerable information about McGrath and all his activities, by far the greater part of which must have come from Roy Garland, probably over more than one meeting. DC Cullen certainly saw Roy Garland at least once more after the initial meeting of 1 March 1974 when he was given the letters he showed to ACC Meharg. The title of the JC 2 document as

162 KIN 55012.
163 KIN 40689.

an "Intelligence Log" relating to McGrath, and its contents, show that this was indeed the case. As DC Cullen had gone to see ACC Meharg, we consider it most unlikely that he continued to have contact with Roy Garland after 1 March 1974 and gathered so much information, unless he believed that this was what ACC Meharg wanted him to do.

233 Why then was the "investigation" effectively no longer being pursued by July 1974? DC Cullen told the Hughes Inquiry he had approached the ACC several times and felt that as a DC perhaps he was overstepping the mark, so he left it to the ACC to make a decision and come back to him.[164] It is clear the ACC never did so, and ACC Meharg told the Hughes Inquiry it was his understanding that if there were any developments DC Cullen would keep him informed.[165]

234 We consider the information given to DC Cullen by Roy Garland in 1974 was sufficient to require a thorough investigation to be started at that time. We accept that DC Cullen was told by Roy Garland that he had been subjected to a homosexual assault many years before. The suspicion that McGrath was homosexual by itself did not justify a police investigation. That McGrath committed at least one and possibly several homosexual assaults on Roy Garland when Roy Garland was a teenager was a crucial difference from a police perspective. Because there was now a sexual crime or crimes being alleged, even though they happened years before, the necessity for an investigation was surely strengthened by McGrath's position as an employee in a boys' hostel, because that gave him the opportunity to sexually assault other boys. Although Roy Garland seems never to have suggested that he knew of any such assaults, his experiences as recounted to the police clearly indicated that there was a substantial risk that such sexual assaults might have taken place in Kincora. The tragedy is that we now know that this suspicion was fully justified.

235 However, according to DC Cullen's evidence to the Hughes Inquiry, to which we have already referred, the matter was further complicated by Roy Garland's stated reluctance to assist the police further by being prepared to be a witness. The absence of a willing witness creates considerable practical difficulties for the police when considering whether or not to launch an investigation. If there is no other evidence, then a witness who is not prepared to give evidence may not have provided

164 KIN 72187.
165 KIN 72229.

sufficient information to justify starting an investigation, no matter how strong the suspicion.

236 It also has to be remembered that at this time the police did not know of the existence of the Mason file. Had ACC Meharg placed the matter in the hands of a more senior and experienced detective, and not left the matter in the hands of DC Cullen, then at the very least it is reasonable to surmise that a more experienced officer might well have approached the EHSSB and been told of the existence of the Mason file, as did happen in 1976. In that eventuality the situation in 1974 would have been transformed because the RUC would have learned also of the allegations against Mains that gave rise to concern in 1967 and 1971.

237 We are satisfied there are a number of unsatisfactory aspects of this first stage of the Cullen/Meharg investigation. First of all, why did DC Cullen react to the information given to him on 1 March 1974 by contacting a very senior officer the next day instead of going through the normal reporting chain by first reporting this matter to his immediate superiors, if necessary by seeking out his DCI in the absence of his DI?

238 In his letter to the Inquiry, Roy Garland said that he suggested to DC Cullen that he should avoid giving anything to the RUC at Donegall Pass because he believed McGrath had contacts there:

> "The reason why DC Cullen went straight to ACC Meharg was because I told him to avoid giving anything to the RUC at Donegall Pass because I believed McGrath had contacts there. I did not expect senior police officers to be involved with him at that time so it was rank and file constables that I was concerned about."[166]

239 If Roy Garland did make such a suggestion, and DC Cullen did not refer to such a suggestion in his evidence to the Hughes Inquiry, it does not explain why DC Cullen followed his advice and bypassed every one of his superiors to approach ACC Meharg in the fashion he did. DC Cullen's explanation for this remarkable action on his part was that it was a very sensitive matter. We are satisfied that he considered it sensitive primarily because of McGrath's political connections. The longer intelligence log, the JC 3 document, is replete with details of McGrath's political activities and associates, and we agree with the conclusion of the Hughes Inquiry "that the connection between [McGrath's] alleged homosexuality and his employment at Kincora was not their sole or main preoccupation".[167]

166 KIN 130038.
167 KIN 75271.

In our view that conclusion is reinforced by the remarkable way DC Cullen approached ACC Meharg. Mr Caskey, a former D/Ch/Supt of great experience, described that as "extraordinary". We agree.

240 There is one more matter in Roy Garland's letter to the Inquiry which it is appropriate to consider at this stage, and that is his statement that:

> "...Jim McCormick was able to tell me earlier that there were three abusers employed at the Kincora Hostel. In desperation I agreed to speak to a policeman in 1973 followed by a member of Military Intelligence in 1975."[168]

and:

> "By the mid-70s I was informed that three abusers were employed there."[169]

However, in his response to the Inquiry of 30 November 2016 Mr Garland said this about when he learnt of the three abusers.

> "I did not know about three abusers at Kincora 'Before (I) saw D.C. Cullen' in March 1974. However, I may have learnt about the three abusers in the latter part of 1974".[170]

This is material in two respects. First of all, he now says that he learnt about this after he spoke to DC Cullen on several occasions in the earlier part of 1974 and not in 1973 as his earlier account clearly implies. Secondly, he appears to indicate that he is uncertain when he learnt that there were three abusers.

241 Mr McCormick did not make mention of this in his police statements. He is now dead. Roy Garland never mentioned it to the RUC or to Sussex Police in later years. Roy Garland did not say that in his Robophone message in 1973, nor to anyone such as Valerie Shaw or DC Cullen, nor in his articles in the *Irish Times* in 1982. If Roy Garland was told this at the time it means Mr McCormick and he knew something that has never been revealed before. If Mr McCormick had said something of such importance to Roy Garland before he saw DC Cullen we find it very hard to understand why Roy Garland said this for the first time so many years after these events when he has described his actions on so many occasions in the past, and that he has significantly changed the dates on which he learnt this. We do not find his evidence on this matter persuasive.

168 KIN 130048.
169 KIN 130048.
170 KIN 130064-130065.

Roy Garland's Contribution

242 Although Roy Garland never said to anyone that McGrath had abused boys in Kincora, because there is nothing to suggest that he ever said that he had evidence to that effect, he was concerned throughout that McGrath would abuse boys in Kincora based upon his own experiences with McGrath. He confirmed this in his response to the Inquiry of 30 November 2016 when he said:

> "My allegation [to D/C Cullen] was that abuse was highly likely at Kincora and that this should be investigated."[171]

Almost all of the complaints from January 1973 onwards emanated directly or indirectly from Roy Garland. Throughout, he was in an extremely invidious position. He had been involved in homosexual acts with McGrath from his teenage years for a considerable period of time. He had been very involved with McGrath for many years in both business and politics until their business and political relationship ended extremely acrimoniously. If he went to the police or to the newspapers with his suspicions of McGrath his sexual relationship with McGrath in earlier years would be examined, and he was clearly reluctant to fully disclose the extent of that relationship. For example, although in April 1982 he admitted to the Sussex Police that on their first meeting McGrath had opened his trousers and touched him on the genitals, when interviewed by D/Supt Caskey on 12 April 1982 he said the Sussex Police had got him to explain further about McGrath and himself than he would have liked, and that he would have preferred not to have this matter discussed in depth.[172]

243 Nevertheless, despite this reluctance, he told DC Cullen much more about what had occurred, as can be seen from DC Cullen's 1974 documents. We accept that despite his reluctance to discuss the detail of sexual activity with others, Roy Garland disclosed much more relevant detail to DC Cullen.

244 We wish to emphasise that we do not criticise Roy Garland for his reluctance to disclose such detail, nor for his reluctance to be a witness when he spoke to DC Cullen. We repeat that he was in an extremely invidious position. By 1974 he had broken with McGrath, and was making a new life. He was then married with children and a mature student at

171 KIN 130063.
172 KIN 20247 and 20248.

university. Were he to become a witness, this would inevitably require him to disclose the full extent of the homosexual acts, and in the atmosphere of the time that would undoubtedly have resulted in considerable stigma attaching to himself and probably to members of his family.

245 In those circumstances it required considerable courage on his part to speak to DC Cullen at all, and to do so in the way that he did, and we commend Roy Garland for doing so. We also commend him for his unsuccessful efforts before that to ensure that the police and social services were alerted to the risks posed by McGrath to the boys in Kincora. When it was obvious to him that his anonymous and indirect attempts through others to bring these risks to the attention of social services had failed, he was prepared to approach DC Cullen in the fashion that we have described. It was not Roy Garland's fault that his efforts fell on stony ground.

246 We consider that **there were several systemic failings of the Cullen/Meharg investigation in 1974.**

(1) ACC Meharg should never have taken personal control of the matter, but should have directed DC Cullen to report the matter to an officer of suitable rank. Whilst it may be that ACC Meharg made himself available to officers of all ranks who sought advice, as the Sussex Police acidly observed:

> **"In continuing to liaise with DC Cullen over this matter, he was acting not so much as an Assistant Chief Constable, but as a Detective Sergeant, with the disadvantage that unlike a Sergeant he had not worked sufficiently closely with Detective Constable Cullen to fairly assess the officer's capabilities".[173]**

(2) ACC Meharg also failed to ensure that DC Cullen recorded everything said to him by Mr McCormick or by Roy Garland, and failed to ensure that DC Cullen submitted regular written reports on the progress of the investigation.

(3) ACC Meharg failed to properly assess the significance of the sexual allegations, and then failed to issue clear and specific instructions as to what steps should be taken by DC Cullen.

173 KIN 40126.

PART NINE

The 1976 stage of the Cullen/Meharg investigation

247 The Cullen/Meharg investigations remained dormant from July 1974 until January 1976. The Hughes Inquiry stated at 4.109 of their Report that Roy Garland (whom they referred to as Informant B) contacted DC Cullen in January 1976, and expressed his concern that McGrath was still employed at Kincora,[174] although again DC Cullen made no contemporary note of what was said. Roy Garland did not comment on this in his letter to the Inquiry, from which we infer that he confirms he did contact DC Cullen again at this stage. It is clear that DC Cullen was spurred into action by this further approach from Roy Garland because he contacted ACC Meharg on 21 January 1976, when he was instructed to report to RUC Headquarters, "and to bring file".[175] The reference to bringing a file to the meeting implies that he may have told ACC Meharg something of what he had done since their previous meetings in 1974. It also suggests that DC Cullen had compiled some material by then.

248 In any event, they met on 24 January 1976. No record of what was discussed appears to have been made by either DC Cullen or ACC Meharg. We consider it reasonable to assume that because approximately eighteen months had passed since they last met or discussed this matter, ACC Meharg would have asked DC Cullen to remind him about the nature of the allegations, and to say what steps he had taken, and what information, if any, he had gathered. Whatever may have been said, ACC Meharg was sufficiently persuaded that the allegations should continue to be investigated to direct DC Cullen to approach the EHSSB, as McGrath's employers. Why he decided at that time that this should be done cannot now be established. It was an obvious next step and one we consider should have been taken in 1974. That is because if DC Cullen did tell ACC Meharg in 1974 that McGrath had engaged in homosexual acts with Roy Garland in the past, none of the other information DC Cullen had gathered, to judge by the information in the three 1974 documents we have considered, added to that crucial aspect. On the other hand, it may be that it was not until January 1976 that ACC Meharg was told, or fully appreciated, that homosexual acts had occurred, because that might explain why he revived the dormant

174 KIN 75271.
175 KIN 40950.

investigation by instructing DC Cullen to approach McGrath's employers. However, as nothing was recorded by either officer we cannot take that any further.

249 Following ACC Meharg's instructions, DC Cullen arranged to meet Mr Bunting and did so on 19 February 1976. We have already considered this meeting, and the subsequent events, when considering the response of the EHSSB to DC Cullen's approach. It is therefore unnecessary to go over those matters again. It is sufficient to repeat that whilst the meeting was about McGrath, DC Cullen made a passing reference to Mains as being the warden or officer in charge of Kincora. That prompted Mr Bunting to remember the Mason file, retrieve it from a drawer and show it to DC Cullen. He read it, and asked if he could have a copy. Mr Bunting told him he felt that he did not have authority to provide a copy but would seek instructions.

250 At a later meeting on 15 March 1976 between DC Cullen and Mr Bunting, a meeting also attended by Mr Gilliland, DC Cullen was given the Mason file. He took it away, copied it and returned the original later. It would appear he also requested a list of those residents of Kincora who had been there since McGrath's employment started, because he was provided with such a list. It would seem that the list was provided later, because Mr Bunting directed Mr Scoular to have it compiled, and that direction appears to have been given after the meeting on 15 March.

251 In any event, DC Cullen had now obtained significant new information. This was in addition to the allegation against McGrath, which was an allegation from a person who was not willing to be a formal witness. The new information was that a second member of staff at Kincora had sexually approached a number of named individuals. This created an entirely new situation and suggested that there was good reason to believe that another staff member had sexually approached individuals who were named and who should be regarded as important witnesses. Because they were named, they should be traced and interviewed if possible. As well, the police had obtained a list of other residents, past and present, who could be interviewed to see if they had been sexually approached by either McGrath or Mains.

252 ACC Meharg told the Hughes Inquiry that DC Cullen told him about the existence of the Mason file, and although he said he thought it related

to McGrath, he directed DC Cullen to obtain a copy.[176] It is therefore clear that DC Cullen must have reported to ACC Meharg after his first meeting with Mr Bunting on 19 February and before the second meeting on 15 March, although no contemporary record of such a report or meeting exists. ACC Meharg told the Hughes Inquiry that DC Cullen came to see him and discussed the Mason file, and at that meeting he directed DC Cullen to get a copy because he was very anxious to see that file.[177] ACC Meharg insisted to the Hughes Inquiry that although he was anxious to see the file he never received it from DC Cullen.

Transmission of the Mason file to ACC Meharg

253 ACC Meharg told the Hughes Inquiry that he expected DC Cullen to bring the Mason file to him in his office.[178] DC Cullen on the other hand told the Hughes Inquiry that he did not take the copy of the Mason file to ACC Meharg in person, but sent it to him through the internal RUC mail system. He did not make a record of doing so because it was so sensitive. We do not find the implication that the Mason file was never received by ACC Meharg because it got lost in the internal mail system convincing. According to DC Cullen the envelope was addressed to ACC Meharg by name. The comment on this by the Sussex Police is significant:

> "There is, of course, a question mark as to whether Detective Constable Cullen posted a copy of the Harry Mason file to Mr Meharg or not. His previous practice, after obtaining information, was to pass it personally to Assistant Chief Constable Meharg, but when he departed from this habit, the copy of the file went missing. Although papers can go missing in any postal system, in this instance I think it would be wrong to unquestioningly accept that the papers were lost in the internal mail. The envelope containing the copy of the Harry Mason file was addressed to an Assistant Chief Constable, whose name was familiar to everyone using the system. One can accept that letters can be delayed or misdirected, but within an internal system typical of the type commonly in use throughout the United Kingdom Police Forces, letters marked up for Assistant Chief Constables rarely go astray."[179]

176 KIN 72218.
177 KIN 72232.
178 KIN 72235.
179 KIN 40127.

254 Not only did ACC Meharg expect DC Cullen to bring him the Mason file; that DC Cullen would do so would be entirely in keeping with his procedure throughout, because he always communicated significant information to the ACC in person. We consider it improbable that DC Cullen entrusted the Mason file to the internal RUC mail system, or that it got lost in that system. We consider it probable that he did report in person to ACC Meharg that he had complied with his direction, obtained a copy of the Mason file and then gave a copy of that file to ACC Meharg.

255 ACC Meharg accepted to the Hughes Inquiry that although he expected to receive the Mason file, he never followed up when he had not apparently received it. The only explanation he could give for not following that up was that he was in charge of a very busy department.[180] He accepted that the police failed in their duty to investigate,[181] and that it was unfortunate that he failed to follow-up the allegation,[182] and that in neither 1974 or 1976 was there a proper investigation.[183]

256 We are satisfied that ACC Meharg's concessions to the Hughes Inquiry were an acceptance by him that what we have described as the Cullen/Meharg investigation in 1974 and in 1976 was not a proper investigation. We have already expressed our view on the failings of the 1974 stage of the investigation, and it is clear that some of these failings were repeated at the 1976 stage. Proper records were not made by DC Cullen or by ACC Meharg as to what was reported by DC Cullen, nor of the directions that ACC Meharg gave orally to DC Cullen. The direction he did give was apparently limited to obtaining the Mason file, because no subsequent direction appears ever to have been given. He did not pursue with DC Cullen whether the file had been obtained and if so why it had not been passed to him.

257 Given our conclusion that it is probable that DC Cullen did give his copy of the Mason file to ACC Meharg, in those circumstances we consider that it was ACC Meharg's responsibility to give further and adequate directions to someone to ensure that the investigation proceeded. ACC Meharg had taken personal responsibility for the investigation; he should not have done so, either in 1974 or again in 1976, because he should have passed the matter to a senior subordinate to pursue. That

180 KIN 72234.
181 KIN 72378.
182 KIN 72385.
183 KIN 72363.

was particularly the case in 1976, because he should have passed the Mason file to a senior and competent person for further investigation.

258 We consider that the Cullen/Meharg investigation was inept and inadequate at both the 1974 and 1976 stages. **We are satisfied there were the following systemic failings: it was not properly directed nor supervised by ACC Meharg; it was not properly pursued when the existence and contents of the Mason file were made known to the police in 1976 it was not pursued properly in 1976 because no instructions to do so were given to DC Cullen or to anyone else by ACC Meharg.** We consider that the responsibility for these failures rests with ACC Meharg. We have only the explanation that he gave to the Hughes Inquiry why he did not take these steps, namely that it was in effect an oversight on his part because he was in charge of a very busy department. No other explanation has been advanced.

259 The HSCB, as the successor of the Belfast Welfare Authority and the EHSSB, and the PSNI, as the successor of the RUC, both recognise that there were a series of missed opportunities for the discovery of the sexual offences that are now known to have been perpetrated in Kincora against the residents of the hostel during its existence. The term "missed opportunity" can perhaps be applied to some of the failings when they are considered in isolation, such as the failure to take unsubstantiated rumours seriously, or to pursue the RUC more vigorously after learning of the Cullen/Meharg investigation in 1976. However, many of the failings were more serious, notably the failure to refer the Mason file to the police in 1971, the failure of D/Supt Graham in 1974, and the failures of ACC Meharg in 1974 and 1976. We consider a more accurate description of the events we have examined in this chapter is that they amounted to a catalogue of errors on the part of the Belfast Welfare Authority, the EHSSB and the RUC, the cumulative effect of which was to fail to bring the sexual abuse of residents in Kincora to an end. That was only achieved when a thorough police investigation was put in train following the revelations in the *Irish Independent* article of 24 January 1980. Whatever the inaccuracies of that article, and we consider some parts of the article in the next chapter, had the article not been written then these crimes could well have continued unchecked.

PART TEN

Other allegations

260 Some further matters were alleged in the *Irish Independent* article to which we now turn, although as they were examined by the Hughes Inquiry and found by it to be groundless we can deal with them briefly. The first was an allegation that reports on certain cases were destroyed under orders from a senior member of the "Social Services Department". No evidence has ever been forthcoming to show that any such reports were destroyed. Mrs Gogarty told the Sussex Police in 1982 that Mr Morrow told her that Mr Higham told him that Mr Higham had been taken to Stormont and shown a file that "made his hair stand on end". Mr Morrow told the Sussex Police he remembered Mr Higham saying something to the effect that he had seen a file on Kincora which would "make his hair stand on end", but he had automatically assumed that a reference to headquarters meant the DHSS at Stormont. The Hughes Inquiry was satisfied that the DHSS never received the Mason file, and that:

> "Mr Morrow embellished what he was told by Mr Higham when passing it on to Mrs Gogarty, who was thereby misinformed".[184]

261 Another allegation related to a report in the journal *Social Work Today* on 12 January 1982 which said that Brian Todd, who was involved with the 23 January 1974 anonymous call received at the Holywood Road office, claimed to have:

> "Relayed in 1976 information from an anonymous complainant living near the home [i.e. Kincora] that she had seen a member of staff interfering with a boy inside the establishment".[185]

The article went on to say that Mr Todd told Mrs Wilson, and filed a report on the incident which was now (i.e. in 1982) in the hands of the police, and which was one of two complaints that resulted in no prosecution.[186] There is no trace of any such complaint in 1976 ever being received by the EHSSB, or having been investigated by the police. This matter was thoroughly investigated in the Caskey Phase Two investigation. D/Supt Caskey, as he was then, concluded that this was a reference to

184 KIN 75287.
185 KIN 21072.
186 KIN 21073.

the 23 January 1974 anonymous call, and observed that Mr Todd said in an interview with DC Mack that he had a vivid imagination which sometimes ran wild with him.[187] This would appear to be a further example of a mistaken recollection of events from a number of years before being distorted in the account that that person then placed in the public domain.

262 The Hughes Inquiry established that there was no file on the allegations in Strandtown RUC Station, unless of course the investigation following the anonymous phone call in 1973 could be said to be such a file. Nor was there a file in Donegall Pass RUC Station, unless the papers put together by DC Cullen could be so described. No file on any of the allegations had been submitted to the DPP by this stage because no such files existed.

Joss Cardwell

263 Joshua Cardwell, or "Joss" Cardwell as he was always known, was a Belfast councillor for many years. In that capacity he served on the relevant committees that were responsible for Kincora. Until the hostel became the responsibility of the EHSSB in 1973 he was the chairman of the relevant committee, and after 1973 continued his involvement with the hostel as a member of the EHSSB's Personal Social Services Committee. Both these bodies were required by law to have regular visits to Kincora carried out by their members, and he therefore visited Kincora regularly in his official capacity. After 1973 he did so on a rota basis. His name therefore appeared in the Kincora visitors' book on many occasions.

264 On page 101 of *"The Kincora Scandal"* Chris Moore claimed that Joss Cardwell was a member of a small homosexual coterie which included Mains and the late John Young, who was the Town Solicitor in 1971 when the decision was made not to refer the Mason file to the police. At pages 110-113 Mr Moore described in some detail the nature and reasons for his suspicions that Joss Cardwell had been sexually abusing children who were residents at Kincora. At page 113 he concluded:

> "It is difficult to avoid the conclusion that Cardwell, with his personal knowledge of Mains, must have been aware of some of the complaints about Kincora going back over the years he served as councillor. He

187 KIN 20520.

must have seen Mains in homosexual activity with some of the more willing participants and as an elected representative his duty was certainly to the welfare of young men in care. Given that Mains was known to treat boys at Kincora by taking them out and about in his car, it is very difficult to believe that Cardwell did not have suspicions."

265 No evidence was given to support the suspicions that Cardwell either sexually abused residents at Kincora himself, or was present when others did so. George Caskey, now retired from the police, gave evidence to our Inquiry in a written statement and in person on Day 217. He confirmed that Joss Cardwell was only questioned by the police because his name was brought up by a journalist, in other words by Mr Moore. He was interviewed by the then D/Supt Caskey and DI Mack on 23 March 1982. He explained that he visited Kincora on many occasions in his capacity as a councillor, but denied ever taking boys out, or having them in his home. He denied attending religious meetings held by McGrath, or knowing that Mains, Semple or McGrath were homosexuals. He recounted that some weeks before, Mr Moore called at his home and said he would like to discuss Kincora. Mr Cardwell also said that he had received a phone call from the representatives of a Dublin newspaper on the same subject. He told both members of the press he would not discuss the matter.[188]

266 On 25 April 1982 Mr Cardwell was found dead in his garage, and an inquest on 28 July 1982 found he died as a result of carbon monoxide poisoning from the exhaust of his car. When re-interviewed on 2 July 1982 by D/Supt Caskey as to the source of his remarks, Mr Moore would not reveal the source of his information, even though Joss Cardwell was now dead.[189]

267 No evidence was given to support the suspicions that Joss Cardwell may have sexually abused residents at Kincora, or been aware of such abuse. In his evidence to the Inquiry on Day 217, Mr Caskey confirmed that at no time during his investigations did anyone make any allegations against Mr Cardwell. So far as our Inquiry has been able to ascertain, no one has ever done so.

188 KIN 20082.
189 KIN 20520.

Concluding remarks

268 In this chapter we have examined the concept of Kincora, the way it was staffed, organised, supervised and inspected. We have also examined the manner in which the Belfast Welfare Authority, followed by the EHSSB and then the RUC responded to concerns that were made known to them about Kincora in various ways and at various times from 1967 onwards. We have expressed our conclusions on the way each of those organisations responded to what they were told. We repeat that it was not simply the case that there were missed opportunities, because we consider there was a catalogue of failure on the part of each of these organisations. It is inevitably speculation, to some degree at least, to try to assess after the event what might have been the result had each failure or missed opportunity been avoided.

269 Nevertheless we are satisfied that there were four major occasions when a thorough police investigation could and should have been brought about. These were the recommendation by Mr Mason in 1971 that the allegations be referred to the police, D/Supt Graham's failure to give proper instructions to Mountpottinger CID, and the initiatives taken by Roy Garland in 1974 and 1976 in approaching DC Cullen that brought about the Cullen/Meharg investigation. We have explained why we consider that the investigation was inept, inadequate and fell far short of being thorough. Each of these occasions could have, and perhaps would have, led to investigations which exposed what had happened so far and as a consequence prevented other residents from being abused.

270 It is true that so far as McGrath was concerned he made no admissions when he was questioned by the police, but Mains and Semple did. Semple was arrested at his home at 8:20am on 1 April 1980, and questioned under caution from 9am onwards. The statement of D/Sgt Graham shows that after a few questions Semple admitted sexual activity with one of the residents. By the time the first interview finished some three and a half hours later, Semple had made a large number of admissions and incriminating remarks implicating Mains and McGrath. Mains was being interviewed at the same time, and by the end of his first interview had also made damaging admissions. Therefore within less than three months from the start of the investigation the RUC had traced, and obtained statements from, several former residents of Kincora, and two of the three members of staff questioned as a result had admitted sexual offences. Had a similar investigation been started

by competent and experienced detectives even as late as 1976, we see no reason to doubt that it would have been successful in exposing what had happened by then. That could have prevented the abuse that was perpetrated by McGrath after 1976 at the latest. Perhaps even in 1974 a similar investigation would have exposed what had happened by then, although McGrath had only assaulted some of the residents that it became clear he had assaulted in later years. Given that any such investigation in 1974 would have involved Semple, who was plainly the most likely of the three to have confessed as he did in 1980, we consider it reasonable to infer that even in 1974 a thorough and competent investigation may have been successful.

PART ELEVEN

Communication from Councillor Jeffrey Dudgeon

271 The Inquiry's programme of public hearings concluded on 8 July 2016 at the end of Module 15. On 14 July 2016 Councillor Jeffrey Dudgeon sent an email to the Inquiry in which he referred to action by the RUC in January 1976 when he and a large number of other individuals were questioned on suspicion of homosexual offences and other matters. Councillor Dudgeon suggested that the RUC actions at that time may explain why ACC Meharg did not pursue the matters reported to him by DC Cullen in January 1976. Mr Dudgeon pointed out that he had been arrested on 21 January 1976 and had been driven home by an officer he thought was DC Cullen. He said this officer:

> "...indicated he was unhappy with what was happening and could not understand why the gay aspect needed pursued in our case. He almost apologised."

272 Mr Dudgeon said this at the end of his email:

> "In conclusion, the RUC Gay Squad was in my opinion acting to stamp out what was felt to be a criminal conspiracy by gay organisations and it would appear that this was the view of ACC Meharg who presumably set the squad up and put the extensive process in train. Plainly it dominated his mind and endeavours over the months from January 1976 (and perhaps a littler [sic] earlier) and as a result, I would suggest, Kincora was not considered worth pursuing. If accurate, it would seem he was well aware and well informed of the subject matter and its complexities."

273 Although the Inquiry concluded its public hearings into Kincora on 8 July 2016, further investigative work was carried out by the Inquiry after that date. Part of that involved a request from the Inquiry to the PSNI to provide a response to Mr Dudgeon's email. The Inquiry subsequently received a further statement from Detective Chief Superintendent Clarke relating to these matters. We are satisfied that Mr Dudgeon is mistaken in his belief that the officer who drove him home on 21 January 1974 may have been DC Cullen. Police records show that it was a different officer, and there is nothing to suggest that DC Cullen, or indeed DC Scully to whom Mr Dudgeon also referred, were involved in any way in these events.

274 We are satisfied there was a police investigation in 1976 which was instigated following a complaint to the police. This investigation, and the manner in which it was carried out, was the subject of complaints by Mr Dudgeon and a number of the individuals involved, relating to matters which do not bear on this Inquiry's consideration of Kincora. We are satisfied that none of those questioned had any connection whatever to Kincora. We are satisfied that ACC Meharg was kept informed of the progress of the investigation, supervised it, briefed colleagues on it, and that it was he who sought and received directions from the DPP.

275 We consider the only relevance of this investigation to the work of this Inquiry is that ACC Meharg supervised what appears to have been a substantial police investigation into alleged homosexual offences during the early part of 1976. The information provided to the Inquiry about that investigation suggests that it appears to have proceeded in a conventional fashion so far as police procedures were concerned; that is quite unlike the way the Cullen/Meharg investigation was conducted in 1974 or in 1976. As can be seen from the events we have examined earlier in this chapter, the Cullen/Meharg investigation was revived in January 1976 following Roy Garland's renewed approach to DC Cullen. We see no reason to believe that the arrest of Mr Dudgeon and others on 21 January 1976, the same day that DC Cullen contacted ACC Meharg, were connected in any fashion. That ACC Meharg behaved in a conventional procedural fashion in relation to one investigation but did not do so in relation to the Cullen/Meharg investigation is clear from our examination of the way in which that was carried out. Events referred to us by Mr Dudgeon do not enable us to explain why there was such a difference in the way in which ACC Meharg dealt with the investigation involving Mr Dudgeon and others and the Cullen/Meharg investigation.

Summary of systemic failings

Belfast Welfare Authority and the EHSSB

276 **There were the following systemic failings in the way Kincora operated.**

(1) Too many children were admitted into Kincora who were too young to be placed in such an environment.

(2) Too many of these children spent too long in an unsuitable environment when they were admitted.

(3) There were insufficient care staff throughout its entire existence, and in particular to deal with the younger children who were placed in Kincora from time to time.

(4) The way the adolescents were looked after in Kincora created an attitude of dependence, exacerbated by inadequate preparation for independent living after they left Kincora.

(5) There were poor terms and conditions of employment for care staff.

277 **The way the 1967 complaints were addressed.**

(1) Mr Mason should have decided that Main's conduct constituted prima facie indication of wrongful conduct.

(2) The Town Clerk's department should have given a clear response to Mr Mason's recommendations, and the response should have been properly recorded.

(3) Clear procedures should have been devised and put in place to ensure that any further complaints in relation to Kincora were reported to the City Welfare Officer.

(4) Clear instructions should have been issued in written form to Mr Moore, setting out the steps he was to take, especially to ensure closer supervision of Kincora in the future.

(5) Mains should have been given a strong and formal warning as to his conduct on this occasion, together with explicit instructions as to how he was and was not to behave in future.

278 **The way the 1971 allegations were addressed.**

(1) The failure by the Town Clerk and the Town Solicitor to refer the 1971 allegations to the Police.

(2) The failure to record the initial interviews of R 8 and R 38 so that these could be added to the Mason file before it was sent to the Town Solicitor.

(3) The apparent failure to record the reasons for not referring the matter to the police.

(4) The failure to inform the chairman of the Welfare Committee of the allegations and the decision not to refer them to the police.

(5) The failure of Mr Mason to take each of the following steps after the 1971 decision not to refer the allegations to the police.

(i) To reiterate that Mains should avoid doing anything with the residents that could lead to allegations of impropriety on his part.

(ii) He should have informed Mrs Wilson and Mr Bunting of the allegations and instructed them to keep a very close eye on both Mains and Kincora.

(iii) He should have put in place a formal procedure within the department in order to ensure that any further allegations about Kincora, and indeed any home or hostel that was the responsibility of the Welfare Authority, should be collated and referred to him, or in his absence to his deputy, for immediate attention.

279 **The failure by Mr Scoular to report the investigation into the allegations against McGrath to the Director of Social Services, and to the police.**

280 **The failure by any of those in social work circles, whether in the EHSSB or elsewhere, who were privy to such rumours to report them to their senior managers or to an appropriate person in the EHSSB if they themselves were employed by the EHSSB.**

281 **The way Mrs Fiddis's report was dealt with by the EHSSB.**

(1) No written record was made of what she had to say.

(2) Miss McGrath did not follow the matter up by contacting Mrs Fiddis to see whether she could add anything to the account she had given to Miss Reynolds.

(3) Miss McGrath did not tell Mr Scoular about the call.

282 **The failure of Mr Scoular to tell Mr Bunting about the January anonymous call when Mr Bunting briefed him on the Cullen/Meharg investigation.**

283 **The response to the Cullen/Meharg investigation.**

(1) The Director of Social Services should have given clear written instructions to Mr Scoular to: (a) increase supervision of Kincora, McGrath and Mains; and (b) to share the Mason file with Miss McGrath and Mr Higham when he succeeded her.

(2) Mr Scoular should have told Mr Bunting about the January 1974 anonymous phone call.

(3) The Chairman and members of the EHSSB, the Chairman of the Personal Social Services Committee, and the DHSS, should all have been informed of the existence of the Cullen/Meharg investigation on a confidential basis, and that it involved a member of the EHSSB staff working in a residential hostel.

(4) Written approaches should have been made by the Director of Social Services to ACC Meharg at regular intervals, starting no later than 17 March 1977, in order to find out what was happening to the Cullen/Meharg investigation.

284 **Mr Scoular's failure to "grasp the nettle", and to report R 18's allegations about McGrath to Board headquarters.**

285 **All communications within the Board relating to these matters should have been properly minuted or recorded and added to the Mason file.**

286 **The failure by Mr Scoular to report the matters relating to R 18 and Richard Kerr to Board Headquarters.**

287 **Mr Blair's failure to find out more about the basis of Mrs Kennedy's concerns, and to tell the East Belfast and Castlereagh Residential and Day Care management about them.**

The Ministry of Home Affairs and the DHSS

288 **There were insufficient inspections of KIncora by central government.**

The RUC

289 **The failure of the RUC to approach the EHSSB at a higher level than Mains was a systemic failing on the part of the police in the RUC division to whom the anonymous call was referred for investigation in 1973.**

290 **The failures by D/Supt Graham to take the following steps.**

(a) Make a record of his meeting with Miss Shaw.

(b) Take adequate steps to launch a formal police investigation.

(c) To give a written instruction for that to be done.

(d) To follow the matter up and leave instructions for his successor.

The Cullen/Meharg investigation

291 **(1) ACC Meharg should never have taken personal control of the matter, but should have directed DC Cullen to report the matter to an officer of suitable rank.**

(2) ACC Meharg failed to ensure that DC Cullen recorded everything said to him by Mr McCormick or by Roy Garland, and failed to ensure that DC Cullen submitted regular written reports on the progress of the investigation.

(3) ACC Meharg failed to properly assess the significance of the sexual allegations, and then failed to issue clear and specific instructions as to what steps should be taken by DC Cullen.

(4) ACC Meharg did not properly direct or supervise DC Cullen.

(5) The investigation was not properly pursued when the existence and contents of the Mason file were made known to the police in 1976 because no instructions to do so were given to DC Cullen or to anyone else by ACC Meharg.

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Kincora, the Intelligence Agencies and HM Government

PART ONE

Introduction

1 This chapter is devoted to an examination of what the security services knew of the sexual abuse of residents in Kincora that we have examined in a previous chapter, and whether any of those agencies exploited, connived in, or ignored the sexual abuse of residents at Kincora (and by security services in this context we refer to the RUC Special Branch, the Security Service (also known as MI5), the Secret Intelligence Service (SIS, sometimes referred to as MI6) and British Army Intelligence). It is essential to bear in mind that this was the focus of our investigation, because although the Inquiry examined a large volume of material in relation to the Security Services this was to see what relevance this might have to Kincora. We were not engaged in a general review of the way intelligence activities were conducted in Northern Ireland in the 1970s, although we have to refer to some aspects of the work of the security services at that time in order to put issues relating to Kincora in their proper context.

2 In this chapter we also examine the responses of various Government departments and agencies over the years to allegations relating to Kincora. As part of that examination we consider the way in which each of the four agencies we have already referred to responded to the allegations that had been made. We also examine the responses by the Ministry of Defence (MoD) and by the Northern Ireland Office (NIO) as the departments of central government primarily involved with the work of the Army and the RUC in Northern Ireland. When we express a critical view of the activities of the non-devolved departments and agencies we do not describe the criticism as a "systemic failing" because we reserve that term for use in connection with the institutions and other bodies examined under our Terms of Reference from the First Minister and deputy First Minister.

The Inquiry's objective

3 In previous chapters we have examined the nature of the sexual abuse perpetrated on residents of Kincora, and the way in which the social services and the police responded to the allegations of actual or suspected sexual abuse of those residents. In this chapter we examine what the security services and Government departments:

1 knew of that sexual abuse;

2 when they knew of it;

3 what they did with any knowledge they had; and

4 what they should have done with any knowledge they had.

4 As part of that examination we considered the various investigations carried out by the RUC which we have referred to as Caskey Phase Two, Phase Three and Phase Four in the 1980s, each of which had a bearing on these issues. In that context we also examined the contacts between MI5 and the RUC, between MI5 and the Attorney General and the Director of Public Prosecutions for Northern Ireland (DPP) prior to the DPP issuing directions in May 1983 following his consideration of the reports on the Caskey Phase Two and Phase Three investigations. We also examined the report issued by Sir George Terry following his investigation, and the circumstances leading to the setting up of the Hughes Inquiry. As we have explained in earlier chapters, many of the allegations relating to what the security services did or did not know about Kincora have come from various individuals, including Colin Wallace and Brian Gemmell among others. It was therefore necessary for us to examine what Colin Wallace in particular has said in considerable detail, as well as the responses of the Prime Minister, various secretaries of state and other ministers in the NIO, the MoD and the Home Office to the matters raised by Colin Wallace over many years. As we shall see, some of the matters raised by Colin Wallace in his voluminous correspondence with ministers, officials, members of parliament and others over many years were not solely related to Kincora, but some reference to those matters will be necessary to place in context matters that did relate to Kincora. We do not consider it necessary to refer to every document we have examined, or to the evidence of every witness, or to every submission by the core participants, or every document sent to us by others such as Roy Garland and Colin Wallace and the arguments advanced by them in correspondence with the Inquiry. We have carefully considered them all and taken them into account.

The structure of our investigations

5 As we have explained, when HM Government approached our Inquiry in the Autumn of 2014 we required, and were given, the following assurances:

1 Details of all files relating to Kincora held by all UK Government departments and agencies would be provided to the Inquiry.

2 A senior civil servant will confirm to the Inquiry at a suitable time whether all relevant files have been produced or accounted for.

3 All the additional costs the Inquiry would incur in investigating the non-devolved UK Government departments and agencies investigated by the Inquiry would be covered in principle by HM Government.

4 That a suitable form of immunity would be provided by the Attorney General for England and Wales for witnesses who cooperate with the Inquiry, and in particular that undertaking would relate to any allegation of an offence arising under the Official Secrets Act.

6 Up to 30 November 2016 the Inquiry spent £532,442 on its investigations into the non-devolved aspects of Kincora, although the final figure will be greater to reflect time spent upon this aspect of our work up to the end of the Inquiry.

7 On 7 January 2015 the Attorney General provided such an undertaking, stating that for the avoidance of doubt:

> "…the undertaking covers any allegation of an offence arising under the Official Secrets Act."[1]

8 On 21 October 2014 the Secretary of State for Northern Ireland also said that:

> "…there will be the fullest possible degree of co-operation by all of HM Government and its agencies to determine the facts.
>
> All Government departments, who receive a request for information or documents from the Inquiry will co-operate to the utmost of their ability in determining what material they hold that might be relevant to it, on matters for which they have responsibility in accordance with the terms of reference of the Inquiry."

1 The undertaking can be found in the Background, Legislation, Protocols, Procedures and Rulings section on the Inquiry website.

Examination of relevant documents

9 Following that assurance the Inquiry provided a list of search terms to the NIO so that all UK departments and agencies could search their records for material which the Inquiry considered might have relevance to its investigation. As can be seen from the list of terms in Appendix 1 this list covered a wide range of subjects and titles. Sir Jonathan Stephens, the Permanent Under Secretary of the NIO, then wrote to all UK government departments and agencies asking them to provide lists of any files held by them which related to the search terms. Not surprisingly some departments and agencies had no contact or connection with Kincora and made nil returns.

10 The Inquiry then examined the lists provided, identified those files which appeared most likely to be relevant to the Inquiry's work, and requested their production. Given the nature of many of the files disclosed to the Inquiry, except for the Chairman it was necessary for those who had not been subject to developed vetting already to be developed vetted before they could examine the files. Developed vetting is the most detailed and comprehensive form of security clearance in the United Kingdom, and is required for individuals who require frequent and uncontrolled access to documents with the highest levels of security classification. References in this chapter to documents being examined by the Inquiry mean that the documents were examined in their un-redacted and complete form, as were the files in which they were contained, by one or more of seven individuals on behalf of the Inquiry. These were the Chairman, both panel members, the Secretary to the Inquiry, the Solicitor to the Inquiry and senior and junior counsel to the Inquiry. Given the nature of the allegations that have been made about Kincora we considered all documents which we examined with a degree of scepticism, whether they emanated from the security agencies or other bodies or individuals.

11 As can be seen from the following list, the Inquiry examined a very large number of files, mainly, but not exclusively, from the departments listed below. For example we examined a small number of files made available to us by the Public Prosecution Service which it had inherited from the Department of Public Prosecutions, and a small number of files were produced to us by the National Crime Agency.

1 The RUC Special Branch[2]

2 KIN 55001-55119.

2 The Security Service[3]
3 The Secret Intelligence Service[4]
4 The Ministry of Defence[5]
5 The Northern Ireland Office[6]
6 The Cabinet Office[7]
7 The Foreign and Commonwealth Office[8]
8 The Home Office.[9]

12 These totals include many files that were not on the original file lists produced to the Inquiry. During our examination of files originally identified to us we identified other files that we considered might be relevant, and asked that these files be produced as well. The department or agency concerned searched for every file the Inquiry asked for, and in the few cases where the file could not be found the reasons why it could not be found were explained to us.

13 Those which appeared to us to be most likely to be of greatest relevance to our work were examined by the Inquiry between May 2015 and the conclusion of the public hearings on Kincora on 8 July 2016. After 8 July 2016 the Inquiry continued to examine the remaining files identified by it as being possibly relevant to ensure that every file that might have some value, however slight, to our work was considered. As part of this post 8 July examination process we identified and examined a substantial number of additional files and documents which had not been previously identified as possibly relevant, and therefore had not been disclosed to the Inquiry, which we considered had some relevance to the issues we examine in this chapter. These documents have been added in redacted form to the evidence bundle for the Kincora Module, and, where relevant, will be added to the other documents displayed on our website. Inquiry counsel and the Inquiry solicitor spent a considerable amount of time on the examination of the additional material, and the process was substantially completed by 28 November 2016. Where we consider the additional documents throw some light on these issues we refer to them in this chapter.

3 KIN 105001-105543.
4 KIN 3501-3648.
5 KIN 102001-102869 and KIN 190001-190217.
6 KIN 103001-103370.
7 KIN 104001-104324.
8 KIN 200501-200614.
9 KIN 185001-185020.

14 As part of its investigation into what the non devolved departments and agencies, and the RUC, knew or did not know about the sexual abuse of residents in Kincora, and what they did or did not do with that knowledge the Inquiry examined and considered many thousands of pages of documents in these files in addition to those to which we referred during the public hearings, those to which we refer in this chapter and those which appear in the evidence bundle. These files are not paginated and we have not sought to count the total number of documents we have examined in different locations. The best way we can describe their volume is that if they were all to be brought together in one location and placed on their sides we estimate they would take up at least 20 metres of shelf space. As will be appreciated from the number and size of the files that were examined, it was an extremely laborious and time consuming process to examine them all before and after the public hearings.

15 We emphasise that in every case where the Inquiry examined a file we examined every part of every document in the file we considered relevant. Many of the files held by the RUC Special Branch, the Secret Intelligence Service, the Security Service and the Ministry of Defence in particular contain references to individuals whose identity was only given in the form of a code name or number in the documents. In every instance where the Inquiry asked for the identity of the person to be disclosed to us that was done. While a great deal of the information contained in many of the files we examined was not relevant to our work, we insisted that all the documents, or parts of documents, that we identified as being relevant be produced to the Inquiry in a form that would enable the relevant part or parts of the document to be publicly disclosed by the Inquiry. As can be seen from the transcripts from the public hearings, the documents, or contents of the documents, were then brought up and displayed by the Inquiry during the public hearings relating to Kincora. The process of checking the remaining files after the end of the public hearings identified more documents which we considered were of some relevance.

16 A senior officer of each department or agency has provided the Inquiry with a statement confirming that their department or agency has identified every file requested by the Inquiry, and produced those they have been able to find. Where they have not been able to find a file because they believe that it has been destroyed they have explained

why that has been done, and, so far as they can, when the file may have been destroyed. Lists of every file examined by the Inquiry in the possession of the PSNI, SIS, MI5, the MoD and the other non-devolved departments and agencies have been compiled by each department or agency and countersigned on behalf of the Inquiry as having been examined by the Inquiry. By nature of their subject the titles of these files themselves contain secret information. The Inquiry required the agencies concerned to provide the Inquiry with file lists and then place them in a secure location known to the Inquiry, and the agencies have undertaken to preserve these lists so that if it is necessary in the future for these lists to be examined they will be available for examination by appropriately authorised individuals.

Publication and redaction of documents

17 Throughout our work on this Module in particular, the Inquiry was conscious of the understandable public interest in documents that have not been publicly available in the past. Throughout we have insisted to all the departments and agencies that all documents that we considered relevant to the issues we set ourselves to examine in relation to Kincora would be made publicly available to the greatest possible extent. As a result of our work, the Inquiry has obtained a considerable quantity of material that has not been previously available. Some of this material would not normally be publicly available, such as reports submitted by investigating officers, for example Detective Superintendent Caskey in the Caskey Phase One, Two, Three and Four investigations, the report (s) by Detective Superintendants Harrison and Flenley of the Sussex Police that were part of the investigation carried out by Sir George Terry, or internal papers of the DPP.

18 While some material that we produced might find its way in due course to The National Archives, other material would not. For example, we have examined files from the MoD, the NIO and the Cabinet Office that fall into this category. As a result of our work we have required material to be made publicly available that normally would never be disclosed publicly. This includes material from files held by the PSNI which it inherited from the RUC Special Branch, and files from the Security Service, from SIS and from the MoD relating to intelligence matters. Wherever possible we required such material to be disclosed in un-redacted form so that it could be made publicly available during the public hearings and eventually placed on our website.

19 We recognised that the contents of some documents we considered relevant could not be disclosed in full. Some of the contents were not relevant, whilst other parts could reveal information that we considered it was not in the public interest to reveal, such as the identities of agents or of those who worked in the intelligence services, whether past or present officers in the RUC Special Branch, members of the SIS or the Security Service, or Army and UDR personnel. In such cases, although we examined the entirety of each document before they were redacted, and, where we considered it necessary, were told the identity of the individuals concerned, portions of documents that we intend to publish have been redacted, i.e. blacked out. Where it is necessary to explain the nature of the identity of an individual, that person has been given a designation, and explanations have been included in the text as necessary to explain the nature of the document.

20 Where the Inquiry identified an individual member of any of the intelligence agencies, a soldier or other person we considered might be able to assist the Inquiry we requested the agency concerned to trace that individual and the Inquiry spoke to them where necessary. Many of those closely involved in these matters are dead, but as we shall see at various stages in the past they described their connection with, or knowledge of, relevant events. With the exception of Brian Gemmell and Colin Wallace those who were still alive and able to give evidence were prepared to do so.

PART TWO

The political and security background

21 The events relating to Kincora that we examine in this chapter have William McGrath and Tara at their centre. We touched upon both in the previous chapter when examining Roy Garland's role during our consideration of the responses of social services and the police to the allegations made about sexual abuse in Kincora. It will be necessary to examine what was, or was not, known about McGrath and Tara in this chapter, but before doing so it is appropriate to briefly describe the wider political and security background of the time. That is because the events we examine in this chapter happened several decades ago, some as far back as 50 years ago, and those events have to be viewed against the background of very different times to those of the present day.

22 What follows is a very brief summary of some of the main political and security events in Northern Ireland between October 1968 and the publication of the Irish Independent article of 24 January 1980, to which we referred to in previous chapters. We selected October 1968 as our starting date because the confrontation between civil rights marchers and the RUC at a march in Derry which had been banned by the Minister of Home Affairs is generally regarded as marking the start of what proved to be more than three decades of unprecedented violence and political instability in Northern Ireland. 1980 has been chosen because that was when the investigations into Kincora may be said to have started following the commencement of the RUC investigation to which we have already referred and which we describe as Caskey Phase One.

23 The first relevant event involving McGrath happened in 1966, and as most of the events with which we are primarily concerned happened more than 40 years ago, some of those referred to in this chapter are dead. The history of Northern Ireland throughout these decades was extremely complex and highly contentious. It has been the subject of many scholarly works, as well as innumerable polemic works, newspapers articles, radio and television programmes, some of which we refer to later in this chapter. It is not the task of this Inquiry to attempt to review the wider history of Northern Ireland during this period, but in order to place the matters we have considered in their proper context it is necessary to make some reference to parts of that wider history.

In the following paragraphs we only refer to some important dates and events in order to indicate something of the gravity and complexity of the political and security landscape relating to Northern Ireland affairs at that time. As some of these events remind us, violence relating to Northern Ireland was not confined to the geographical area of Northern Ireland, as Loyalist and Republican bombings in the Republic of Ireland and in Great Britain which caused major loss of life demonstrated.

Some key dates and events

24

- 5 October 1968 – confrontation between civil rights marchers and RUC at a banned march in Derry.
- 21 April 1969 – British troops from 39 Brigade were sent to guard public buildings and utilities.
- 24 April 1969 – Terence O'Neill resigned as Prime Minister of Northern Ireland.
- 12 August 1969 – prolonged rioting spread to other areas in Northern Ireland resulting in sectarian clashes, notably in Belfast where hundreds of houses were destroyed by fire. It was later estimated that 1.6% of all households in Belfast were forced to move in July, August and September 1969. 1,505 of these were Roman Catholic families, 315 were Protestant. These amounted to 5.3% of all Roman Catholic families, and 0.4% of all Protestant families in Belfast.
- In succeeding years, thousands of people from both communities were forced to move from areas where they were in the minority. In 1974 the Community Relations Council estimated that 60,000 in Belfast, more than 10% of the population, had moved by February 1973. Other areas outside Belfast saw smaller but significant population movements.
- 14 and 15 August 1969 – the United Kingdom Government agreed to the deployment of regular Army troops in Derry and Belfast.
- 1 April 1970 – the Ulster Defence Regiment (UDR) was inaugurated. This was a locally recruited unit of the British Army under Army command.
- 30 April 1970 – the Ulster Special Constabulary was disbanded. A largely part-time force, the B-Specials as they were generally known, consisted of over 8,000 part-time armed special constables.

- 18 June 1970 – the United Kingdom general election resulted in the defeat of the Labour Government which was replaced by a Conservative Government with Edward Heath as Prime Minister.
- 9 August 1971 – suspected terrorists were detained without trial under the Civil Authorities (Special Powers) Act (Northern Ireland) 1921 (commonly known as the Special Powers Act). Internment, as this was generally known, lasted until 5 December 1975. During this time 1,981 individuals were detained; 1,874 were regarded as Catholic/Republican, 107 were regarded as Protestant/Loyalists.
- 30 January 1972 – thirteen men were shot dead and seventeen wounded by members of the Parachute Regiment in Derry.
- 24 March 1972 – the United Kingdom Government announced the suspension of the Northern Ireland Government, and the prorogation of the Northern Ireland Parliament, a decision which received legal effect on 30 March 1972 with the enactment of the Northern Ireland (Temporary Provisions) Act 1972.
- 31 July 1972 – the British Army carried out 'Operation Motorman' during which thousands of troops removed barriers around what had been known as 'no go areas' in Belfast and Derry. These were areas where barriers or barricades had prevented the security forces from entering various areas of the cities.
- 28 June 1973 – elections were held for a new Northern Ireland Assembly.
- 22 November 1973 – a new power-sharing Northern Ireland Executive was announced.
- 28 February 1974 – a United Kingdom general election resulted in the formation of a minority Labour Government on 4 March with Harold Wilson as Prime Minister.
- 15 May 1974 – the Ulster Workers Council, a loyalist group, threatened widespread civil disobedience unless fresh elections were held in Northern Ireland.
- 17 May 1974 – car bombs in Dublin and Monaghan in the Irish Republic killed 33 people and injured over 120.
- Widespread power cuts and factory closures across Northern Ireland followed the call from the Ulster Workers Council.
- 19 May 1974 – the Secretary of State for Northern Ireland declared a State of Emergency.

- 27 May 1974 – the British Army took over a number of petrol stations in Northern Ireland to ensure the maintenance of petrol supplies.
- 28 May 1974 – the Chief Executive and other Unionist members of the Northern Ireland Executive resigned.
- 10 October 1974 – following a further general election the minority Labour Government was returned to office with an overall majority of three seats.
- 22 November 1974 – nineteen people were killed and 182 injured in explosions at two public houses in Birmingham.
- 20 December 1974 – the Provisional IRA declared a temporary ceasefire lasting from 22 December 1974 until 2 January 1975. The temporary ceasefire was later extended to 17 January 1975.
- 1 May 1975 – elections were held in Northern Ireland for a Constitutional Convention.
- 3 May 1979 – the United Kingdom general election resulted in the return of a Conservative administration with Margaret Thatcher as Prime Minister.

The level of violence

25 The intensity of the violence in Northern Ireland during the years 1969 to June 1977 can be seen from the following figures.[10]

1969 to 1977	
Deaths	1,768
Injuries	19,947
Shootings involving the security forces	16,465
Shootings not involving security forces	9,636
1970 to 1977	
Bomb attacks	8,314
Vehicles hijacked	4,143
Malicious fires	2,086

10 Cmnd. 7009 The Protection of Human Rights by Law in Northern Ireland, p.6. (published November 1977).

1969 to 1976

Compensation for personal injuries £25,498,153

1971 to 1976

Compensation for damage to property £190,585,130

26 As we shall see when we consider Colin Wallace's allegations, 1974 was a very violent year. In the eleven months up to and including 30 November 1974 there were 205 deaths, 648 explosions and 3,052 shootings.[11]

27 We have given this relatively brief survey of the political developments, and the scale of the violence, to convey something of the gravity and complexity of events in Northern Ireland throughout the last years of the 1960s and the 1970s. When examining the events relating to William McGrath, Tara, Kincora and the various individuals, it is easy to fall into the trap of ignoring the backdrop of events within which the departments, agencies and individuals whose actions we examine in this chapter were operating.

The structure of Government

28 Following the suspension of the Northern Ireland Government in March 1972 a new department of the United Kingdom Government was created. The Northern Ireland Office (NIO) was responsible for administering Northern Ireland. It was under the leadership of the Secretary of State for Northern Ireland and as such its function was essentially two-fold. As part of the United Kingdom Government the Secretary of State was answerable to Parliament for the actions of the entirety of government in Northern Ireland.

29 The structure of devolved departments and administrative structures of the Northern Ireland Government that existed before direct rule continued to function largely as before under the control of the Secretary of State and his junior ministers. The Secretary of State and his junior ministers were therefore also answerable to Parliament for all of those aspects of government which previously had been the responsibility of the devolved Northern Ireland Parliament, the Northern Ireland Government and its ministers. This included the Department of Health and Social Services, which was the Northern Ireland department responsible for childcare

11 Cmnd. 5847 Report of a Committee to Consider, in the Context of Human Rights, Measures to Deal with Terrorism in Northern Ireland, p62.

matters, although the administration of the childcare services was the responsibility of four regional health and social services boards. As we have seen in previous chapters, Kincora Boys' Hostel was the responsibility of the Eastern Health and Social Services Board.

The Security Services

30 Before we turn to examine the material relating to the individual security services it is appropriate to explain their respective structures and functions. As was the case with other United Kingdom police forces, the RUC had a separate Special Branch which was responsible for gathering information relating to terrorist organisations, and those organisations and individuals who might be considered to be involved in, or who might be thought to be likely to become involved in, terrorist crime. Special Branch was a separate department within the RUC structure, with its own officers stationed in each RUC division across Northern Ireland. The RUC Special Branch was answerable to the head of the RUC. The chief officer of the RUC in 1969 was the Inspector General, and after that for almost all of the period with which this Inquiry is concerned was the Chief Constable. Whilst the Chief Constable exercised operational independence, he was answerable to the Secretary of State.

31 The Ministry of Defence was responsible for the British Army and related bodies operating in Northern Ireland in aid of the civil power. The involvement of the British Army in peace-keeping operations in Northern Ireland from August 1969 meant that very soon there were several thousand regular troops serving in Northern Ireland at any given time. From April 1970 they were supported by the locally recruited Ulster Defence Regiment (UDR) which grew until it comprised several thousand full-time and part-time soldiers. The UDR was organised in battalions on a territorial basis and commanded by regular Army officers.

32 The regular Army units and UDR were under the control of the General Officer Commanding in Northern Ireland (GOC) who was a lieutenant general. Under the GOC was the Commander Land Forces in Northern Ireland (CLF), who was a major general and responsible for the day-to-day control and direction of all regular Army and UDR units in Northern Ireland. These units were in turn attached to one of three brigades, each of which had responsibility for a specific geographical area. The GOC and CLF were based at Army Headquarters for Northern Ireland (HQNI) at Thiepval barracks on the outskirts of Lisburn.

33 Both regular Army and UDR units engaged in intelligence gathering about individuals and matters they considered had a bearing on their operations, and this was carried out at a number of levels. HQNI had a number of officers whose task this was, as did each brigade and each unit. Our attention focused primarily on the HQNI and brigade intelligence, but it will be necessary at some point to make reference to other Army intelligence personnel.

34 Both the Secret Intelligence Service (SIS) and the Security Service (MI5) operated in Northern Ireland during this period. In the initial period of their involvement it is clear to us that there was considerable confusion about their respective roles, and the roles of the Army and the RUC, as well as a lack of effective coordination between the police, Army, the SIS and MI5. It was not until the establishment of direct rule in 1972 that an Irish Joint Section (IJS) was established by MI5 and SIS with jointly staffed offices in both Belfast and London.[12]

35 MI5 described the role of the IJS in Northern Ireland to the Inquiry

> "…as comprising a small number of Security Service and SIS agent running officers focused on obtaining strategic and political intelligence about the plans and intentions of paramilitary organisations."[13]

It is apparent from the material we have examined that when MI5 and the SIS ran agents under the auspices of IJS it is not always straightforward to establish now which of the two agencies was responsible for a particular agent at a given time.

36 From 1969 MI5 had a liaison officer attached to RUC Headquarters at Knock. In 1972 the Secretary of State for Northern Ireland established the post of Director and Coordinator of Intelligence (DCI) to act as both his personal security advisor and his main link with the GOC and Chief Constable. The first DCI was appointed from outside MI5 because no-one of sufficient seniority was prepared to accept the post. However the post was held by MI5 officers from 1973 onwards. In his The Defence of the Realm the Authorised History of MI5 Christopher Andrew described the DCI's role.

> "The title…was a partial misnomer. DCIs never directed intelligence operations in Northern Ireland. Their main function was intelligence liaison and coordination, which in the early 1970s were difficult and sometimes thankless tasks."[14]

12 KIN 3505.
13 KIN 4079.
14 p.261.

37 The DCI had two subordinates in Northern Ireland who acted as senior liaison officers with the RUC and the Army. The DCI Rep Knock was stationed at RUC HQ, whilst his representative at Army HQNI at Thiepval operated under the cover title of Assistant Secretary (Political) or ASP. According to MI5, the IJS was not under the direct control of the DCI.[15]

38 By the end of 1974 the DCI, according to Christopher Andrew, had become an influential figure. He had become the chief intelligence advisor of the Secretary of State, ran an office which produced daily intelligence summaries, and acted as the channel for passing intelligence on Northern Ireland to the Joint Intelligence Committee (JIC) in London.[16] We have occasion to refer to the DCI and the daily intelligence summaries later. However, it is clear from the material we have examined that the DCI was not the sole channel of intelligence from Northern Ireland, because both SIS and MI5 officers reported to their respective colleagues in London on an extremely frequent basis.

39 Whilst there was a significant sharing of information between the RUC, MI5, the SIS and the Army at various levels, to a considerable degree each operated independently of the others. On occasions some information gathered by one organisation might be shared with another by individual officers on an unofficial, personal basis, the receiving agency then being wary of revealing to the other agency that it had obtained such information. A further complication is that it was official policy that certain information was withheld from the RUC because of fears of leaks from within the RUC to paramilitary organisations or political figures. In order to establish what each agency did or did not know at any given time is therefore not always straightforward.

15 KIN 4079.
16 p.62.6

PART THREE

William McGrath and Tara

40 Whilst we have already referred to William McGrath and Tara in the previous chapter in connection with Roy Garland, it is necessary to examine again what Tara was doing in order to understand why it, and individuals believed to be associated with it, were of interest to the RUC Special Branch, Army Intelligence, MI5 and SIS.

41 William McGrath was born on 11 December 1916. Throughout his adult life it appears he devoted the greater part of his time to preaching the Christian Gospel as a Protestant wherever and whenever he found a willing audience. His audiences appear to have been like-minded individuals in mission halls, churches and Orange halls throughout Northern Ireland, but on occasion he appears to have operated elsewhere, for example in England, in the early 1960s. Much of this activity was organised by him under the auspices of a body describing itself as the Christian Fellowship Centre and Irish Emancipation Crusade, of which he was the secretary. In the 1940s and 1950s he was also the principal figure amongst a group of young men who lived a form of communal life in premises known as Faith House in Finaghy in south Belfast. By the mid-1960s the Finaghy premises had been sold and the Christian Fellowship Centre and Irish Emancipation Crusade was based in 15 Wellington Park, Belfast.

42 By 1969 he had bought a house at 4 Greenwood Avenue in east Belfast, not far from Kincora. He lived at Greenwood Avenue with his wife and three children, one of whom was his son William Worthington McGrath.[17] Although McGrath appears to have devoted most of his time and energy to his religious work, he also carried on a business selling carpets, saying in his application form in 1971 for the post at Kincora that he had been employed for most of his life in the carpet import business.[18] As we have seen in an earlier chapter, although little is known of his financial affairs, these do not appear to have prospered. By 1971, when he obtained the post at Kincora, he was working as a counter clerk in an estate agent's office in Belfast city centre. In June 1971 he took up the position of housefather in Kincora at 236 Upper Newtownards Road.

17 KIN 55073-55074.
18 KIN 1213.

43 We have already referred to the business relationship between William McGrath and Roy Garland in the previous chapter, and it is sufficient to say that the relationship ended acrimoniously with Garland obtaining a judgement against McGrath for the then substantial sum of £1,280.40 in February 1972.[19] Following his appointment to the post at Kincora, McGrath sold the house at Greenwood Avenue and moved to a house at 188 Upper Newtownards Road. This was very close to Kincora, although when he actually made the move is unknown.

44 McGrath's involvement with the Christian Fellowship Centre and Irish Emancipation Crusade continued when he moved to 4 Greenwood Avenue to judge by a leaflet issued by that body with the address 4 Greenwood Avenue which was found at Manchester airport on 17 December 1971, and notified to RUC Special Branch amongst others by Cheshire Constabulary.[20]

45 McGrath was also active in the Orange Order, and in 1970 was instrumental in the formation of a new Orange Lodge known as "Ireland's Heritage". From the mid-1960s onwards his political views found expression in various ways, notably through Tara. In the previous chapter we have considered Tara in the context of Roy Garland's involvement with it and with McGrath. For present purposes it is sufficient to say that according to Roy Garland the origins of Tara were to be found in a "private group of Orange men" which he joined in 1965. In 1966 he said the group changed its name to Tara and McGrath became chairman. Tara's members were supporters of the Union between Northern Ireland and Great Britain, and in its early years it would appear that many of its members, such as Roy Garland and others, were young and active in the Unionist Party. In his *Irish Times* article of 14 April 1982, Roy Garland described how Tara evolved in the period from November 1969 and January 1970 into a paramilitary group which met in the Clifton Street Orange Hall in north Belfast under the cover name of "the Orange Discussion Group".[21]

46 Tara was organised on a paramilitary basis with McGrath as the Commanding Officer (CO) and Garland as second in command. "Platoons" commanded by "Sergeants" were formed, with each platoon responsible for its own affairs. On 12 August 1971 Tara distributed

19 KIN 1684.
20 KIN 55075.
21 KIN 55014.

a statement in working class areas of Belfast, part of which reads as follows:

> "...we call on all members of our Loyalist institutions, and other responsible citizens, to organise themselves immediately into platoons of twenty under the command of someone capable of acting as Sergeant. Every effort must be made to arm these platoons with whatever weapons are available. The first duty of each platoon will be to formulate a plan for the defence of its own street or road in co-operation with platoons in adjoining areas. A structural Command is already in existence and the various platoons will eventually be linked in a co-ordinated effort. ...We are loyalists, we are Queen's men! Our enemies are the forces of Romanism and Communism which must be destroyed."[22]

47 A clandestine organisation avowedly organised on paramilitary lines, claiming to have a command structure, ostensibly seeking armed members, and, as subsequently became apparent, a large proportion of whose members at one stage were members of a loyalist terrorist organisation, would naturally be of considerable and legitimate concern to the various intelligence agencies. Their duty would be to find out as much as possible about the membership, structure and objectives of such an organisation in order to see whether the organisation posed a threat to others, or might do so in the future, and to enable the Government to react accordingly if necessary. When considering what the various departments and agencies we examine in this chapter did, or did not know, it is essential to bear in mind throughout why Tara was of interest to those departments and agencies.

The efforts of RUC Special Branch and MI5 to identify the officer commanding of Tara

48 In this chapter we refer to various documents that have emanated from the agencies which we are examining. In each case the Inquiry has examined not only the original of that document in unredacted form but the entire file or group of files containing that document. The documents to which we expressly refer have all been examined by the Inquiry and we only consider it necessary to refer to some of those documents. The documents we consider relevant can be examined in their full redacted form when placed on the Inquiry website.

22 KIN 55014.

49 When examining the contents of the documents that contain information about McGrath, Tara and other individuals named in the documents, it is essential to bear in mind throughout that the information gathered was not necessarily true, or accurate in every respect. The files we are considering plainly contain information of varying degrees of reliability that had to be assessed or verified. Depending on the source from which it came, the information could range from the well-informed and authentic at one extreme to idle and ill-informed malicious gossip at the other, that had no foundation in fact and may have been circulated to smear individuals. Whilst we now know that McGrath committed sexual crimes of a homosexual nature against residents in Kincora, it does not follow that references at the time to him being homosexual were necessarily accepted as true. Put simply, everything in the files is not and was not necessarily true.

50 The RUC Special Branch files show that the first time McGrath came to the attention of the RUC Special Branch was on 7 July 1966 when he was reported as being present on the platform at a rally held by the Reverend Ian Paisley in the Ulster Hall in Belfast. Further details were obtained, and by 5 August 1966 the records listed his date of birth, address and occupation as secretary of the "Christian Fellowship and Irish Emancipation Crusade". That body was described as a "pro-loyalist organisation and every opportunity is taken to display the Union Jack on its premises".[23]

51 The RUC Special Branch does not appear to have had any interest in, or information about, Tara until June 1971 when it received a report from MI5 with information dated 16 June 1971. This report contained some information about Tara and its leader based on a report of a meeting attended by a source who referred to "the officer commanding, a man called McGrath".[24] The Special Branch then opened a file on the "Tara Brigade" in June 1971[25] and it is probable that the file was opened because of the information received from MI5.

52 A reference in the MI5 document to the Commanding Officer being "a man called McGrath" is significant because there were no other details apart from the surname to enable the person to be further identified. The response of Special Branch was to issue two sets of instructions

23 KIN 55068.
24 KIN 55100.
25 KIN 55085.

on 31 August 1971. The first, by the Assistant Chief Constable (ACC) Special Branch was directed to "All Special Branch Officers" and commenced with the following sentence:

> "In recent times we have had intelligence to the effect that a Protestant/Loyalist organisation known as the 'Tara Brigade' exists in the Province."

The document went on to describe what was known about the membership, structure, geographical spread and objectives of Tara. The penultimate sentence read:

> "Give this matter close attention. Where confirmation already exists report immediately. Where it does not, developments should be reported as they come to hand."[26]

53 The second document issued on that date took the form of an instruction from a superintendent at RUC HQ on behalf of the ACC Special Branch to the detective sergeant of Special Branch at Dungannon RUC station in which the writer said about Tara that:

> "It has not to date been identified with U.S.C. [Ulster Special Constabulary] Associations or any of the other well known loyalist groups."

Referring to the "man named McGrath" the instruction continued that it had been suggested that this person "might be identical with George McGrath" whose Dungannon address was given. Details of the appearance of the "man named McGrath" were given and a photograph believed to be that of George McGrath was attached. The recipient was directed to report with a full description and "if at all possible a recent photograph".[27]

54 On 24 September 1971 RUC Special Branch sent MI5 two copies of a photograph of George McGrath.[28] On what appears to be 20 October 1971 MI5 responded by saying that the source had been shown the photographs and confirmed that George McGrath was not the same person named "McGrath" he had seen at the Tara meeting earlier in the summer of 1971.[29] On 23 November 1971 Special Branch headquarters wrote to the detective sergeant in Dungannon Special Branch confirming

26 KIN 55087.
27 KIN 55088.
28 KIN 55089.
29 KIN 55113-55114.

that George McGrath of Dungannon was not the person sought.[30] We must make it clear that the George McGrath of Dungannon referred to in these exchanges had no connection whatsoever with William McGrath.

55 A Special Branch HQ two-page instruction of 3 December 1971 to four Special Branch local offices giving more details of the membership and activity of the Tara brigade concluded with the sentence that the commander:

> "…is said to be a George McGrath and the Intelligence Officer Clifford Smith."[31]

So although George McGrath had been eliminated as a candidate for the McGrath said to be leader of the Tara brigade, Special Branch still believed that the McGrath was called George, or perhaps had simply mistakenly continued to call that person George McGrath.

56 We have already referred to the communication to RUC Special Branch (amongst others) from Cheshire Special Branch of 18 December 1971 relating to the Christian Fellowship Centre and Irish Emancipation Crusade leaflet found at Manchester airport the day before. That communication appears to have prompted RUC Special Branch to enquire into that organisation on 10 January 1972, when RUC HQ said that "a William McGrath" was the occupier of 4 Greenwood Avenue, Belfast. It is noted that the person on record at that address was William Worthington McGrath, who was William McGrath's son. The request to Belfast Special Branch was:

> "Please have discrete enquiries made and furnish a report of what can be learned of McGrath and his activities and of the 'Christian Fellowship Centre and Irish Emancipation Crusade'."

57 That request resulted in the 1966 entry on William McGrath being copied by the local Special Branch to Special Branch headquarters. As we have seen, the 1966 record identified William McGrath as the organiser, gave his date of birth and his address as 15 Wellington Park. It is noteworthy that the conclusion of the writer was that "this person [ie William McGrath] is obviously the father of William Worthington McGrath".[32]

30 KIN 55115.
31 KIN 55091.
32 KIN 55067.

58 William Worthington McGrath, but not his father, was already the subject of a Special Branch file, and the other Special Branch file referred to dealt with the Christian Fellowship Centre and Irish Emancipation Crusade, and not Tara. That suggests William McGrath only came to the notice of the RUC Special Branch again in January 1972 when he was identified as being connected with his son Worthington and with the leaflet found at Manchester airport the previous month. The possibility that William McGrath might be the person named as "McGrath" believed to be the commander of the Tara brigade was not suggested.

59 The next indication of RUC Special Branch information on Tara is to be found in a Special Branch report of 15 March 1972, which referred to:

> "...reports that the Tara brigade is now finally disbanded. McGrath, who was its leader, has not been seen since the first two weeks in December 1971. McGrath is a Civil Servant who was last working on the problem of drug addiction in Northern Ireland it is believed. He also holds the M.B.E."[33]

60 So far as the identity of the person referred to as McGrath was concerned, the information given in the March 1972 report was clearly inaccurate in so far as William McGrath was concerned. Although he was now working in Kincora and therefore was an employee of the Eastern Health and Social Services Board, and so could perhaps be mistakenly described as a civil servant, there is nothing to suggest that he ever worked on drug problems in Northern Ireland or held the M.B.E. Not only is the information inaccurate as far as he was concerned, but again the William McGrath of 4 Greenwood Avenue does not appear in the document as connected with Kincora.

61 RUC headquarters informed Belfast Special Branch on 6 April 1972 that "the Tara brigade is now disbanded. McGrath who was its leader has not been seen since December 1971."[34] The report also referred by name to various other individuals who it was said held subordinate positions in the Tara brigade.

62 The last 1972 record relating to Tara is a document dated 7 April 1972, which appears to have emanated from MI5 in London. This document refers to Clifford Smith as the "IO [Intelligence Officer] of the Tara brigade"

33 KIN 55092.
34 KIN 55093.

who was thought to have "changed political horses".[35] It was not until a year later that either RUC Special Branch or MI5 files contained any reference to Tara or the identity of its Commanding Officer.

63 The next record relating to Tara on the RUC Special Branch files is a report from a Special Branch officer stationed at Newtownards in County Down dated 17 April 1973. This report referred to a press announcement about Tara of 11 April 1973, and gave details of Tara's structure and some of its leading figures, including its Commanding Officer who was named as William McGrath of 3 Greenwood Avenue.[36]

64 This document is significant for a number of reasons. First of all, although William McGrath had been identified on Special Branch records in 1966, and identified in January 1972 as the occupier of 4 and not 3 Greenwood Avenue, in both instances he had been identified as the secretary of the Christian Fellowship Centre and Irish Emancipation Crusade, not as the Commanding Officer of the Tara Brigade. The records suggest that it was not until April 1973 therefore that he was identified by Special Branch as being the person who had been first named in June 1971 as the Commanding Officer of the Tara Brigade. Thereafter it appears to have taken some 20 months for Special Branch to connect the William McGrath of Greenwood Avenue with the person named McGrath who had been named as the Commanding Officer of the Tara Brigade. William McGrath had been working as a housefather in Kincora since June 1971, and so he had been working there for almost exactly the same length of time that had elapsed during which some efforts had been made – unsuccessfully – to identify the McGrath named as the Commanding Officer of the Tara Brigade in June 1971.

65 Secondly, until the press announcement in April 1973 the Tara Brigade had not been known publicly, although some named individuals had been reported as being amongst its senior personnel in earlier Special Branch records. This is an indication of the clandestine nature of the existence of the Tara Brigade at that stage.

66 Thirdly, the report said that the membership of the Tara Brigade "had been falling drastically and they went public to create a myth about its size". That suggests that the assessment of the author of the report was that this meant that the Tara Brigade was of less significance because of its falling membership.

35 KIN 55020.
36 KIN 55076.

67 Fourthly, the report referred to McGrath's sexual behaviour in the final passage in the following terms:

> "The C.O. McGrath is a reputed homosexual and he is alleged to have kept members ensnared in the organisation by threatening to reveal homosexual activities which he had initiated. He used the Irish Emancipation Christian Fellowship, Wellington Park, Belfast as a front for Tara. Membership has been falling drastically and they went public to create a myth about their size".[37]

The officer submitting the report commented that "Further details, when obtained will be submitted."

68 It is noteworthy that the report refers to McGrath as "a reputed homosexual" without giving any details as to whatever information was available to support that assertion. The reference to McGrath being "alleged to have kept members ensnared in the organisation by threatening to reveal homosexual activities which he had initiated", strikingly anticipates the tenor of the anonymous Robophone message from Roy Garland to which we have referred in the previous chapter and which we examine again in the next paragraph. It is significant that the entire emphasis of this report is on the Tara Brigade.

Special Branch and the Robophone message

69 The next document received by RUC Special Branch relating to McGrath came some five weeks later when it received a copy of the anonymous Robophone message of 23 May 1973 from Roy Garland. We have set out the text of the Robophone message in full in the previous chapter, and it is therefore unnecessary to set it out again. The Robophone message expressly linked McGrath to what it called "a secret Militant Organisation known as Tara", and that was no doubt why it was sent to Special Branch for consideration.[38] The Robophone message was also sent to the Divisional Commander of E Division in which Kincora was located, and as we have stated in the previous chapter there then followed an investigation by the local police from Strandtown RUC Station, who duly reported on their findings through the chain of command to Divisional Headquarters and then to RUC Headquarters.

37 KIN 55076.
38 KIN 55077.

70 The Robophone message alleged that McGrath was centred in a "Vice Ring" based in his new address at 188 Upper Newtownards Road, and his occupation was given as a "social worker at Kincora Boys' Hostel, 236 Upper Newtownards Road". The details of McGrath's home address, occupation and work address added considerably to the information about McGrath which was now available to Special Branch and which we have so far considered.

71 Although Special Branch had received information only five weeks earlier that alleged McGrath was a "reputed homosexual" who was "alleged to have kept members ensnared in [Tara] by threatening to reveal homosexual activities which he had initiated", there is nothing to suggest that Special Branch shared this information with their CID or uniformed colleagues. The information was clearly of some relevance to the enquiries that had been put in train in relation to the Robophone message. On the face of it, the Special Branch Report of 17 April suggested that there was another source or sources known to Special Branch who alleged that McGrath was a reputed homosexual, who "ensnared" members of Tara and had initiated homosexual activities. This information placed the allegations about McGrath on a more substantial basis than was the case so far as the Robophone message was concerned, because CID could then have requested Special Branch to approach the source or sources of their information to see whether there were individuals to whom CID or Special Branch could speak, or lines of enquiry which could be followed, in order to see whether there was other evidence to corroborate the serious allegations made by the anonymous author of the Robophone message.

72 Whilst the source or sources of the information on which the 17 April 1973 Report was based might not have been able or willing to advance the investigations, the information in the Report of 17 April was potentially relevant to the Inquiry that had been ordered by RUC Headquarters. We believe that that Report should have been shared by Special Branch with CID in the first instance. If there was Special Branch concern about revealing a source, that was something that should have been discussed at an appropriate level within the RUC. There is nothing whatever to suggest that that was done, even though Special Branch was kept informed of that investigation, because a copy of the Report on Constable Long's investigation was placed on the Special Branch file on McGrath.[39]

39 KIN 55079.

73 We are satisfied that Special Branch should have made the information contained in the 17 April 1973 Report known to the appropriate level of CID so that that information could be shared in an appropriate way with those carrying out the investigation directed as a result of the Robophone message. **We consider that the failure of Special Branch to share this information, or even consider how it could be shared, with their CID colleagues in the first instance was a systemic failing on the part of Special Branch.** Whether that would have materially affected the outcome of the investigation that was carried out by Strandtown RUC is clearly a matter of speculation because we do not know what additional information the source or sources upon which the 17 April 1973 document was based could have contributed.

PART FOUR

RUC Special Branch interest in Tara and McGrath after the Robophone message

74 The Special Branch records we have examined show that from time to time over the following months throughout the remainder of 1973 Special Branch received additional intelligence relating to McGrath. A report of 17 October 1973 dealt with information from a source on another matter, in the course of which the source referred to Tara. The source said that it was a splinter group formed from the UVF and was run by McGrath from his house on the Holywood Road, that he had been told Tara had 500 Thompson machine guns and that "Tara was 'very secret' and was not generally known to exist". This suggests that the source was not particularly well informed, because McGrath was never known to have lived on the Holywood Road, and as Tara had issued a press release earlier that year it could not be said to be 'not generally known to exist'.[40]

75 Another brief Special Branch report referred to McGrath as being of the Christian Fellowship Centre at 188 Upper Newtownards Road, and to have a supervisor named "Mayne", presumably a mistake for Mains.[41]

76 The next, and a more significant, Special Branch document relating to McGrath is a letter to MI5 by RUC Headquarters dated 22 November 1973. This letter was copied to the DCI at Stormont Castle. The letter said it was believed McGrath was intending to visit Amsterdam on an unknown date, to visit a named person for an unknown purpose and that the person named was not known to Special Branch. Two parts of the letter are relevant to the issues for this Inquiry. The first is that the letter identified McGrath by name, date of birth, occupation, place of work and national insurance number. Although Kincora was mentioned as McGrath's place of work, the greater part of the letter referred to his role in Tara, saying that he "has been the subject of a number of reports as being the Officer Commanding Tara Brigade in Northern Ireland". The letter continued:

> "Intelligence on this group, which is believed to have close links with the Ulster Volunteer Force and the Orange Order, show that it was

40 KIN 55098.
41 KIN 55097.

> dormant for some time prior to the 11 April 1973 when it made a public announcement in the press of its re-formation. Little threat is offered by this group at present and while it has claimed a large membership throughout Northern Ireland it is in fact a small group of people operating in Belfast with a very small membership."[42]

77 Whether or not all of the information was accurate, the references by Special Branch to Tara, that it was believed to pose "very little threat" and it being "a small group of people operating in Belfast with a very small membership", are indications that by that time Special Branch considered the Tara Brigade to be a relatively insignificant group.

78 It is not until the summer of the following year that there are to be found any Special Branch documents relating to Tara or the Tara Brigade. It appears that an advertisement was placed in the Belfast Newsletter on 20 June 1974 by Tara, and this sparked a query from an Assistant Chief Constable at RUC Headquarters to the superintendent at Belfast's Special Branch the same day. The ACC wrote:

> "It is now sometime since we heard of the Tara Brigade which we first heard of as a par-amilitary outfit...please update as to present constitution, personalities, aims, objects, etc."[43]

79 This request appears not to have been responded to by Special Branch until November 1974 when a superintendent replied. Having described the origins of the Tara Brigade he wrote:

> "...the Tara Brigade we now know are not activists or militants, but are a group of people who are genuinely concerned about the situation in Northern Ireland.
>
> The following persons are known to be associated with the Tara Brigade:
>
> (1) William McGRATH, DOB 11.12/1916.
>
> This man was Secretary of the Christian Fellowship and Irish Emancipation Crusade".[44]

80 Coincidently, shortly after the ACC's requests of 20 June 1974, the arrest of a boy at Kincora for theft resulted in the discovery of Tara leaflets in his locker in the home, and Special Branch was notified.

42 KIN 105010.
43 KIN 55045.
44 KIN 55046.

Entries on a Special Branch Records Action Slip of 6 July 1974 and 30 July 1974 noted that McGrath was a housefather at Kincora, and that a pamphlet written by him had been published by the Christian Fellowship and Irish Emancipation Crusade of 15 Wellington Park, Belfast.[45]

81 No further references to McGrath had been found on Special Branch files until April/May when MI5 sought information about the Tara Brigade and William McGrath because of its interests in the Liverpool UVF. The RUC response referred to both William McGrath and his son Worthington McGrath, giving some background information about Tara and concluding with the following passage:

> "The McGrath's are regarded as being somewhat eccentric and unstable. Reports had been received that McGrath Senior is a homosexual, though we have nothing to confirm. It is possible that he was involved in the beginning of the re-birth of the UVF in 1972."[46]

82 The absence of any Special Branch records relating to McGrath thereafter, other than being told about a leaflet sent to the Chief Constable by McGrath on behalf of Tara in May 1977,[47] suggests that McGrath was of little interest to Special Branch after 1975 or thereabouts. Other than occasional newspaper articles that referred to Tara and were noted in passing, Special Branch appear to have had no interest in Tara or the Tara Brigade for several years prior to the publication of the *Irish Independent* article of 24 January 1980[48] to judge by a lengthy report submitted on 4 February 1980.[49]

83 As part of our examination of material relating to what RUC Special Branch did or did not know, and did or did not do, in respect of Kincora, we examined the two-part Special Branch File on the Tara Brigade, a file called the Kincora Boys' Home Scandal, and files on the following nine individuals:

1 William McGrath[50]

2 Worthington McGrath[51]

3 George McGrath[52]

45 KIN 55044.
46 KIN 55103.
47 KIN 55026.
48 KIN 11529.
49 KIN 55047.
50 KIN 55072.
51 KIN 55065.
52 KIN 55112.

4 Roy Garland[53]

5 Clifford Smith[54]

6 James Millar[55]

7 Colin Wallace[56]

8 Robert Fisk[57]

9 Maurice Oldfield[58]

84 We also examined a number of other Special Branch files that might have some relevance to the issues we are considering in this Report. The documents to which we have specifically referred in the preceding paragraphs are the only documents from all of these files that are relevant to Kincora that were created by RUC Special Branch, or received by it from other RUC departments or from MI5. The contents of the small number of documents to which we have referred from all of these files suggest that RUC Special Branch first learned of McGrath in 1966. From June 1971 until April 1973 they were attempting to identify the individual who was identified only by the surname of McGrath and reported to be the Officer Commanding of a clandestine group known by Special Branch as the Tara Brigade. In January 1972 Special Branch learnt William McGrath was the author of a pamphlet published by the Christian Fellowship Centre and Irish Emancipation Crusade, of which McGrath was the secretary.

85 Special Branch do not appear to have made the connection between William McGrath in that capacity and the person named McGrath whom they were attempting to identify as the Commanding Officer of the Tara Brigade until April 1973. Thereafter, their interest in him was clearly because of his position as the Commanding Officer of the Tara Brigade. As the Tara Brigade was not believed to be a threat, and was believed to have significantly reduced in numbers, it is clear from the content of the documents we have described that Special Branch had no real interest in Tara, and therefore in William McGrath, from November 1973 onwards.

53 KIN 55006.
54 KIN 55017.
55 KIN 55001.
56 KIN 55023.
57 KIN 55105.
58 KIN 55053.

86 We have explained why we regard the failure of RUC Special Branch to tell their colleagues in CID of the Special Branch Intelligence that McGrath was "a reputed homosexual" who was alleged to have kept members of Tara ensnared by threatening to reveal homosexual activities he initiated to be a systemic failing by Special Branch. During our comprehensive examination of the Special Branch files we found nothing whatever that suggests McGrath was ever a Special Branch agent, or that Special Branch were aware of any allegations that McGrath was abusing residents in Kincora.

87 Tara was a clandestine paramilitary organisation and, as such, other RUC officers examining allegations that referred to McGrath and others alleged to have some connection with Tara should have thought to explore with Special Branch whether it had any intelligence relating to the allegations that McGrath was homosexual and believed to be a risk to the boys in Kincora where he worked. Just as Special Branch did not tell their CID colleagues about the intelligence Special Branch received in April 1973, there is nothing to suggest that D/Supt Graham, DC Cullen, or ACC Meharg ever contacted their Special Branch colleagues to see if Special Branch had any information about McGrath's links with Tara, or about the allegations he was homosexual and the possible implications of that for boys at Kincora. **We consider the failure of D/Supt Graham, DC Cullen and ACC Meharg to contact their Special Branch colleagues to find out if Special Branch had any information about McGrath that might assist their enquiries to be a systemic failing.**

McGrath's links with MI5 and Tara between June 1971 and January 1976

88 Before we consider the evidence relating to MI5, McGrath and Tara it is appropriate to repeat that the Inquiry has examined a large number of files held by MI5 which we considered might be relevant in some way to the issues we examine in this report. When we examined many of those files we were satisfied that by far the greater part of the files were not relevant to these issues. Some files did contain material that could be said to have had some relevance to those issues, however slight, but even those files contained substantial numbers of documents which were not relevant to those issues in any way.

89 Other documents which were relevant also contained irrelevant information, or information which we accepted had to be redacted to protect the identities of officers of MI5 or SIS, or those who are now referred to in the current terminology as a Covert Human Intelligence Source or CHIS.

90 Throughout our work we have approached our task on the basis that the Inquiry would make as much of an original document publically available as possible so that the authenticity of the document can be seen, and we have taken the same approach when dealing with MI5 and the other intelligence agencies. Many of the documents from MI5 were referred to during the public hearings relating to Kincora. After the public hearings were completed the Inquiry examined other MI5 documents, which we requested to see, or which were disclosed to us by MI5. Where the Inquiry considered that part or all of those other documents had some relevance to our work they have been produced to the Inquiry in the same redacted form as earlier documents, and will be included in the MI5 documents placed on our website at the conclusion of the Inquiry. While we have not considered it necessary in this report to refer to every document, or every part of a document, produced to us during the public hearings or subsequently, the result of our work has been that a large number of MI5 documents whose contents would never have been shown to those who were not members of the Security Service have been examined in their unredacted entirety by us, and made publicly available for the first time, albeit in redacted form.

91 We have already explained something of the structure of MI5 in Northern Ireland during the period we have considered, and it is appropriate at this stage to consider what the role of MI5 was. This was explained to the Inquiry by a member of the Security Service referred to as Officer 9004, whose identity is known to the Inquiry. He made a number of witness statements, to some of which were exhibited disclosed MI5 documents. Two of these statements were made for the public hearings. The first statement of 30 May 2016 was effectively superseded by the second statement of 20 June 2016 which repeated the material in the previous statement, but dealt with an additional issue. At the conclusion of the Inquiry's post-hearing examination of other MI5 documents, Officer 9004 produced a further statement dated 29 November 2016. That statement, and the documents exhibited to it, can be found at KIN 4135 onwards in the Kincora documents.

92 During the public hearings Officer 9004 gave evidence to the Inquiry by live TV link, and his evidence can be found on the Inquiry website on Day 219. In addition to those parts of the structure we have already described, he explained that although the first Assistant Secretary Political (ASP) was a member of SIS, the subsequent ASPs all came from MI5.

93 The role of the Irish Joint Section (IJS) which consisted of the SIS and MI5 was to:

> "...help to illuminate the security situation as it was developing in Northern Ireland at that time, bearing in mind that the Province was politically very unstable and there were an awful lot of worries that the situation might get out of control or it might even approach civil war".[59]

94 He went on to explain that the focus of the IJS was:

> "...very much on the strategic and the sort of political at the top end of the paramilitary spectrum. The police were heavily engaged at the time in the insurgency that the Provisional IRA and the Loyalist Paramilitaries [sic] continue groups were mounting. Our focus was much less tactical that than. It was much more strategic, and some of the agents that we were running at the time were providing effectively political intelligence that was not directly relevant to counter-terrorist policing work."[60]

95 The evidence of Officer 9004 was that whilst McGrath was identified as one of the leaders of what he described as "a potentially threatening organisation", namely Tara, "he just wasn't all that important to us at the time".[61] He also said:

> "Tara was a potential threat, not an actual threat at most stages, and McGrath was a relatively peripheral figure to us".[62]

96 It is noteworthy that MI5 did not create a permanent file on McGrath until May 1977,[63] and the references to McGrath and to Tara or the Tara Brigade during the 1970s were few in number and intermittent. The first reference to McGrath is to be found in a report in mid-June 1971 by

59 Day 219, p.14.
60 Day 219, p.15.
61 Day 219, p.27.
62 Day 219, p.116.
63 KIN 4051.

an MI5 CHIS on a meeting he attended with a large number of loyalists which was addressed by a person who the source only referred to "as a man named McGrath" who was the "Officer Commanding" of "the Tara Brigade". This man explained:

> "...the aims of the organisation as the preparation of an effective defence force against the day when it would be required. He emphasised that those joining would not be required to undertake offensive action, but would be required to carry out drill and a certain amount of intelligence work".[64]

97 In the previous chapter we referred to the public statement issued by Tara in working class loyalist areas in August 1971, and the record of the June 1971 report also says that a new MI5 file was being opened entitled "the Tara Brigade". It is not until April 1972 that the next reference to the person named McGrath in the June 1971 Report is to be found. That came in a letter written by James Miller dated 7 April 1972 in which he reported being told by a third party:

> "...that Tara CO McGrath had been accused of assaulting small boys and that he could not account for any cash that had been handed to him over a period of twelve months".[65]

We consider the significance of the reference to the accusation that McGrath "had been assaulting small boys" later in this chapter, and at a later stage we shall also refer to the letter when considering what James Miller did or did not say in an article in the *Sunday Times* issue of 29 March 1987.

98 Earlier in this chapter we described the efforts by the RUC and MI5 from June 1971 onwards, to establish the identity of the man called McGrath identified in the June 1971 Report, as the Officer Commanding of the Tara Brigade. The next MI5 record relating to McGrath does not appear until a report of 18 April 1973 was recorded on a card index. This described him as the "leader of the refurbished form of the Tara Brigade".[66] We have found no report relating to that entry, but the date of 18 April 1973 suggests this information may well have come from the RUC Special Branch note typed on 17 April 1973, to which we have already referred.[67]

64 KIN 15002.
65 KIN 105005.
66 KIN 105008.
67 KIN 55076.

99 The next entry on the card is to a document of 29 November 1973 which states:

> "he runs the Christian Fellowship Centre qv (same ref as above) Subject "gets them young and preaches religion to them" which means he preaches bigotry and anti-catholic sermons. Possibly also a member of the UVF."

The card then contains a further reference to a document of 13 November 1973 before adding:

> "188 Upper Newtownards Road, Belfast. OCC: Boys Hostel Warder [sic] at Kincora Boys' Hostel, Belfast. He runs the Irish Emancipation Crusade, 4 Greenwood Avenue, Belfast, which sent threatening letters to Birmingham firms. Reported to be homosexual. He has long made a practice of exploiting other people's sexual deviations and Paisley has expressed strong animosity towards subject".[68]

100 The date of 29 November 1973, the details of McGrath's address and occupation, are consistent with having come from the RUC letter of 22 November 1973,[69] and the references to McGrath being homosexual and "exploiting other peoples' sexual deviations" echoes the RUC Special Branch Report of 17 April 1973 and so may have come from RUC Special Branch. However the references to the "Irish Emancipation Crusade" having "sent threatening letters to Birmingham firms", would suggest that information had been gathered outside Northern Ireland.

101 A Daily Intelligence Summary of 17 January 1976 referred to a report in March 1975 that McGrath was the Warden of the Kincora Boys' Hostel. In April 1975 the Army passed information to MI5 in the form of a summary of allegations about McGrath which was said to have come from Valerie Shaw, to whom we have referred in another chapter.[70] Apart from referring to McGrath's address of 188 Upper Newtownards Road, and to his being the "Warden" of Kincora, this document dealt primarily with McGrath's relationship with the Reverend Ian Paisley and with Roy Garland.

102 In May 1975 Merseyside Police Special Branch sent a message to MI5 relating to the origins of the UVF and saying that it had grown out of Tara. The message did not name McGrath, but referred to the instigator of the Liverpool Tara as a:

68 KIN 105008 and 105009.
69 KIN 55118.
70 KIN 105011-105013.

> "'queer' [who] returned to Belfast where he was investigated by Loyalists who decided because of his homosexual tendencies he constituted a security risk".[71]

Although the person is unnamed we agree with Officer 9004 that it is likely that the person referred to was McGrath.

103 The Daily Intelligence Summary was a summary sent by the DCI to a wide range of recipients. That of 17 January 1976 was numbered 725A, and the extract relating to McGrath is as follows:

> "comment: William McGrath was reported in March 1975 to be Warden of Kincora Boys' Hostel. He has previous Tara traces and is said...to be a homosexual. Another regular and reliable source has recently indicated that the UDA, and also William Craig, may be aware of this Tara / UVF activity in the arms field."[72]

104 Pausing at January 1976, the very occasional and sparse references to McGrath in the contemporary MI5 records suggest a number of things. Firstly, MI5's interest in the Tara Brigade was because it was part of what Officer 9004 aptly described as "the quite grey, murky area between Protestant Paramilitarism and the Protestant Politics of the day".[73] Secondly, it was because someone named McGrath had been identified as the Commanding Officer of the Tara Brigade that this person came to their attention. Thirdly, it was not until April 1973 at the earliest, possibly not until November 1973, that MI5 were able to establish completely that the man named McGrath and believed to be the Officer Commanding of the Tara Brigade was one and the same as the William McGrath who worked in Kincora. Fourthly, the references to McGrath's homosexuality are not associated with his work at Kincora.

Ian Cameron, Roy Garland and Brian Gemmell

105 In the previous chapter we examined the various efforts made by Roy Garland to alert social services and the police to the dangers he believed (correctly as events have shown) which McGrath posed to the residents of Kincora. In his letter to the Inquiry of 26 September 2016 Roy Garland said that he "also agreed to speak with a Christian Military Intelligence Officer in 1975", and described being taken to Thiepval

71 KIN 4048.
72 KIN 4046.
73 Day 219, pp. 34 and 35.

Barracks by "another MIO". Later in the letter Roy Garland said that Jim McCormick, to whom we have also referred in the previous chapter in connection with Roy Garland, introduced him to Brian Gemmell in 1975. Although Roy Garland did not say who it was they discussed, it is reasonable to infer that the "Christian Military Intelligence Officer" was Brian Gemmell. It is therefore appropriate to describe who Brian Gemmell was and how he came into contact with Roy Garland. Before we do so, we should point out that Brian Gemmell also declined the Inquiry's invitation to become a core participant. He was requested to provide a witness statement to the Inquiry but did not do so, although it would appear from references in Roy Garland's letter of 26 September 2016 that Brian Gemmell and he had corresponded about evidence considered by the Inquiry during the public hearings relating to Kincora.[74]

106 Brian Gemmell was a graduate of Strathclyde University, where he was active in student politics. Before he graduated he had decided to join the Army and hoped to get a short service commission, if possible in the Intelligence Corps. In February 1971 he applied to join MI5, but was advised to get more experience and to return some years later if he was still interested.[75] He then joined the regular Army, was commissioned into the Intelligence Corps and served in Northern Ireland between December 1974 and 1976 as a captain attached to 123 Intelligence Section of 39 Brigade based in Lisburn and Belfast.[76]

107 Brian Gemmell was an Evangelical Christian, and through his contacts in those circles he was introduced to the Carryduff veterinary surgeon Jim McCormick, who introduced DC Cullen of the RUC to Roy Garland in 1974. We have examined what transpired between DC Cullen and Roy Garland as a result of that introduction in the previous chapter when we considered the Cullen/Meharg investigations. In his police statement of 16 July 1982 made during the Caskey Phase Three investigation Brian Gemmell said, "it was well into my tour that I met Roy Garland through James McCormick of Carryduff".[77] He said that there were two meetings, one in McCormick's house and the second in Lisburn when he was accompanied by his Sergeant, witness Q. Garland said in his letter to the Inquiry of 26 September 2016 that he was introduced to

74 KIN 130022.
75 KIN 105001.
76 KIN 30145.
77 KIN 30145-30147.

Brian Gemmell in 1975, and witness Q said in his police statement that it may have been in the summer of 1975, and that witness Q left the province in February 1976.[78]

108 In October 1976 Captain Gemmell met two officers who, unknown to him, were officers in SIS and not, as he believed, MI5 Officers. He gave them two documents that SIS recorded him as describing as coming from his Army files. One of these came from 3 Brigade in Lurgan[79] and was signed by Major Halford McLeod. We shall refer to this again later in this chapter. However it is appropriate to point out that this document is an example of how one intelligence agency might come into possession of a document belonging to another intelligence agency unofficially. At the time SIS said the document "was obtained unofficially",[80] although on 31 January 1977 it was recorded that Gemmell had no objection to it being discussed with the Army.[81]

109 The other document was described as:

> "Notes on interview with Roy Garland. These were made by Gemmell and an NCO after a "one off" debrief sanctioned by Ian Cameron".[82]

Ian Cameron was an MI5 officer attached to HQNI at that time as the ASP, and was a significant figure in the events we examine in this chapter. The NCO was witness Q.

110 In 1982, in his police statement, Brian Gemmell said that after his second meeting with Roy Garland he wrote a four page Military Intelligence Source Report or MISR.[83] We shall refer to the MISR again when we consider the connection of the Ministry of Defence with Kincora in due course. There is an issue as to whether or not Brian Gemmell took part in a second meeting with Roy Garland, or whether that meeting was with witness Q, and we shall consider the evidence relating to that shortly. The document which we are satisfied was prepared by Brian Gemmell after a meeting with Roy Garland runs to just over one page. It is inexpertly typed, which would suggest it was a rough note or aide memoire rather than a finished document.[84] The information in the note refers to the history of Tara,

78 KIN 2569.
79 KIN 3510.
80 KIN 3508.
81 KIN 3510.
82 KIN 3509.
83 KIN 30146.
84 KIN 30313 and 30314.

and to a number of individuals who were alleged to be members of, or sympathetic to, Tara. The information clearly came from Roy Garland, who is described in the document as "RG" and who "claims to have been 2IC [second in command] to [McGrath]".

111 The sole reference in this document to McGrath's sexual proclivities is where it is recorded what are referred to as "youngsters"

> "...held meetings themselves and [McGrath] would single them out after meeting. [McGrath] attempted to seduce them by claiming to show them emotional freedom. To this end he made them feel guilty by admitting to masturbation, therefore showing up their guilt complex. This is important to emphasis as it is the very beginning of [McGrath's] hold on them".[85]

112 The other document handed over by Brian Gemmell at the same time was headed "Note to file 3350/18 Volume II" and dated 14 October 1976. It is a three page, typed document and provides considerable detail about the origins of Tara, its structure and objectives. Whilst the report refers to 'sources' some of the information appears in the note of the meeting with Roy Garland. Other references suggest that the author(s) had access to other sources of information, such as the statement:

> "Military intelligence and RUC Special Branch records have about 30 names of members or former members of the organisation in the Belfast area".

The OC is described as "William McGrath, 5 Greenwood Avenue, may be stood down due to ill health".[86]

The inaccurate reference to 5 and not 4 Greenwood Avenue, when McGrath had been living at 188 Upper Newtownards Road since at least 1973, is an indication of how details in such documents may be inaccurate.

113 The only reference in a long three-page, closely typed document to McGrath's sexual proclivities is a single sentence:

> "There is evidence that a number of the members are sexual deviant; William McGrath the past OC almost certainly is bisexual and there were homosexuals in his immediate circle of TARA associates".[87]

85 KIN 30313.
86 KIN 105029.
87 KIN 105027.

114 There are a number of significant features of the information contained in these documents when both documents are considered together. First of all, the emphasis throughout is predominantly on the Tara Brigade, its origins, membership, aims and objectives. Secondly, McGrath is named because it is thought that he may still be the leader, although there is clearly some doubt about that. Thirdly, although there are references to his sexual proclivities in seducing 'youngsters' the context clearly relates to members of the Tara Brigade. Fourthly, there is no reference to Kincora or to McGrath's position there, or to residents of Kincora being sexually abused by McGrath. Finally, there is no reference either to other abusers being on the staff at Kincora either then or in the past. In the previous chapter we have referred to Roy Garland's allegation in his letter to the Inquiry of 26 September 2016 that Jim McCormick told him "that there were three abusers employed at the Kincora Hostel".[88] It is significant that there is no such reference in either of the two contemporary documents in which Brian Gemmell referred to McGrath and referred to what Roy Garland had told him. The first such reference that the Inquiry is aware of appears to have been made by Brian Gemmell in a *Belfast Telegraph* article of 6 August 2014, where he is reported as saying that:

> "The third source was Mr McCormick, an evangelical Christian, who set up a meeting between Mr Garland and Mr Gemmell in 1974. Mr McCormick said at the meeting that there were three child abusers working at Kincora."[89]

Witness Q

115 He was initially a corporal, and then a sergeant, who served in Northern Ireland under Brian Gemmell, who was then Captain Brian Gemmell. Witness Q made a statement in 1982 during the Caskey Phase Three investigation when he described how he met Roy Garland with Captain Gemmell "about the summer of 1975" at Jim McCormick's house.[90] It was arranged at that meeting that he would meet Roy Garland again and bring him to 123 Section HQ at Thiepval, but the meeting did not take place as planned because he was told by Captain Gemmell that an instruction had been given that it was forbidden to see Roy Garland

88 KIN 130039.
89 KIN 3544.
90 KIN 30148-30149.

again. However, that decision was changed and a second meeting did then take place.[91] It would seem likely that witness Q was therefore the second Military Intelligence Officer (MIO) to whom Roy Garland referred in his letter to the Inquiry of 26 September 2016.[92]

116 In addition to providing a statement to the Inquiry, witness Q gave evidence by Livelink on the morning of Day 223, the last day of the Inquiry's public hearings into Kincora and the last day of the Inquiry's programme of public hearings. Witness Q made it clear that before he met Roy Garland he was aware from Jim McCormick's comments that Roy Garland said that he had suffered some sexual abuse from McGrath in the past. When he met Roy Garland he thought that what Roy Garland described was not ongoing, but had happened before. From the outset of their discussions, witness Q was aware that McGrath was a figure of some authority in a boys' home. He recalled that it was probable that he prepared either a hand-written, or a typed, note of what had transpired at the second interview which he provided to Brian Gemmell who then translated that into the poorly typed document to which we have referred[93] before witness Q destroyed his original notes. He was positive that Brian Gemmell did not attend the second meeting that he had with Roy Garland. He described how he was told before the second meeting that he was to keep the discussion to Protestant extremism and to stay away from any sexual references.

117 In the event it proved almost impossible to steer Roy Garland away from McGrath's sexual perversions. He particularly recalled Roy Garland saying that McGrath "tried to get us to go with animals", something that stuck in his mind over the years. He was emphatic that the name of the boys' home was never mentioned and that he had never heard of Kincora until it became news in the 1980s.

118 We found witness Q to be a straightforward witness who was doing his best to help the Inquiry by recalling events that occurred over 40 years ago. We are satisfied that, as Roy Garland said in his letters to the Inquiry, there were two meetings, and that witness Q was present at both. The first took place in Jim McCormick's home. The first meeting between Brian Gemmell and McCormick appears to have taken place on 25 March 1975 according to MI 5 records, which refer to ASP

91 KIN 2570.
92 KIN 130019.
93 KIN 30313.

authorising a meeting with Garland on 4 April 1975 after an earlier meeting with McCormick on 25 March 1975. Both meetings with Roy Garland are therefore likely to have taken place in 1975 on dates after 4 April 1975.[94]

119 Witness Q was present when Roy Garland spoke to Brian Gemmell at the first meeting. We accept that the second meeting took place at Thiepval, and are satisfied that Brian Gemmell was not present when witness Q interviewed Roy Garland on that occasion. We accept that witness Q subsequently reported the details of that meeting to Brian Gemmell, and having done so then followed the usual procedure by destroying his notes of that second interview.

120 We are satisfied that after the first interview it was clear to both Brian Gemmell and witness Q that Roy Garland's purpose in speaking to them was to convey his concerns about McGrath's sexual proclivities and that after the first meeting that must have been reported to the ASP. Ian Cameron was the ASP and initially decided that there should be no further contact with Roy Garland, but changed his mind and agreed that a second meeting could be arranged. Ian Cameron ordered that the meeting should concentrate solely on Tara and Protestant extremism.

121 We are satisfied that after his experience with the first interview, witness Q believed that it would prove very difficult to prevent Roy Garland from talking about McGrath's sexual proclivities, and it is noteworthy that the reference to going with animals quite understandably remained in his mind to the present day, given the nature of the allegation.

122 It is clear from witness Q's account of the second meeting with Roy Garland that, as he anticipated, it proved very difficult to keep Roy Garland to the topic of Tara. We are satisfied that during both meetings witness Q believed from what Roy Garland was saying that Roy Garland's experiences with McGrath had happened in the past and were not current. We are also satisfied that although witness Q was aware of McGrath before the first meeting, and aware of rumours that McGrath was homosexual, and believed him to be a person of some authority in a boys' home, the name Kincora was never mentioned to witness Q, and witness Q believed that Roy Garland's concerns about McGrath were based on his past experiences and not on any current connection with McGrath.

94 KIN 4134.

123 In paragraph 17 of his Inquiry witness statement witness Q said that in the second interview Roy Garland:

> "...again referred to the abuse of boys at a boys' home connected to the Protestant community".[95]

When asked by Inquiry Counsel whether he might have conflated the references to abuse of boys with his knowledge that McGrath worked in a boys' home, witness Q said that while he still had the impression that Roy Garland was saying that McGrath was abusing boys in a boys' home, he could not discount that he had conflated the two pieces of information.

124 We consider it significant that Kincora was never mentioned, and that there is no evidence to suggest that Roy Garland ever alleged to anyone that McGrath was abusing boys in Kincora. The entire thrust of all of the accounts that had been recorded by numerous individuals, or in accounts that he has given, was that he believed boys in Kincora were at risk of being abused. It is also significant that the notes made by Brian Gemmell of his meeting with Roy Garland do not mention Kincora or refer to abuse of boys in Kincora, but do refer to McGrath's sexual proclivities.[96] Nor did Brian Gemmell mention Kincora or record that McGrath was believed to be abusing boys in Kincora, in the much longer and more detailed three-page report dated 14 October 1976 which he handed over on 15 October 1976 to two people who he mistakenly believed to be MI5 officers (but were in fact MI6 officers).

125 We have considered the possibility that, because witness Q and Brian Gemmell had been told not to become involved in discussions about homosexuality with Roy Garland, when they reported the outcome of that discussion they left out references to Kincora and boys in Kincora. We can see no reason for their doing so, and there were references to McGrath's homosexuality in the contemporary documents created by Brian Gemmell which suggest that they did report the allegations about McGrath's homosexuality that came from Roy Garland even though the instruction from Ian Cameron had been to steer away from the issue of homosexuality.

95 KIN 2562.
96 KIN 30313 and 30314.

126 Having carefully considered witness Q's evidence, we were satisfied that in this instance he mistakenly conflated what Roy Garland told him about McGrath abusing young people such as himself in the past with his prior knowledge that McGrath was in a position of some authority in an unknown boys' home. We are satisfied that Roy Garland did not mention Kincora by name, or say that McGrath was abusing boys in Kincora, but said he was concerned that McGrath could be abusing boys without specifying the location or the circumstances.

PART FIVE

Ian Cameron, Brian Gemmell and the MISR

127 In the preceding paragraphs we have referred to instructions given by Ian Cameron in his position as ASP to Brian Gemmell about what topics were to be considered when Brian Gemmell and witness Q spoke to Roy Garland, and the MISR Brian Gemmell said in 1982 that he had submitted. Ian Cameron was an MI5 Officer seconded to HQNI, where he served as the ASP and discussions with Brian Gemmell are important in establishing what MI5 did or did not know about McGrath's abuse of residents of Kincora. As we shall see when we come to examine the efforts by the RUC to question Ian Cameron as part of the Caskey Phase Three investigations, what Ian Cameron did or did not say to Brian Gemmell in the context of the discussions between Brian Gemmell and Roy Garland, and whether or not there ever was a MISR, are intertwined. It is therefore convenient to discuss the evidence relating to all of these matters at this stage.

128 Brian Gemmell was one of those whom the Inquiry invited to become a Core Participant in Module 15. At the same time he was also requested to provide the Inquiry with a witness statement addressing a number of questions posed to him by the Inquiry. He did not accept our invitation, nor did he produce a witness statement. The correspondence between him and the Inquiry in which these questions were set out can be found on our website at Day 204. Whilst Brian Gemmell explained his reasons for not wishing to participate in the Inquiry or give a witness statement, the Inquiry is aware that in the past he has given media interviews and contributed to newspaper articles about the issues we are examining in this module, and in particular which we now examine. We are also aware that he has been in contact with Roy Garland about some of the evidence given to the Inquiry during the public hearings relating to Kincora, to judge by Roy Garland's reference to their correspondence at page 9 of his letter to the Inquiry of 26 September 2016.[97] The Inquiry was not therefore given the benefit of whatever Brian Gemmell wishes to say about the matters that we now propose to discuss.

97 KIN 130022.

129 As we have already explained, in 1975 Brian Gemmell was serving in Northern Ireland and commanding 123 Intelligence Section attached to 39 Infantry Brigade. As part of the Caskey Phase Three investigations he was interviewed by D/Supt Caskey and made a detailed statement on 16 July 1982. By that time he had left the Army, where he had held the rank of captain. In his police statement he said that his particular responsibility as Commanding Officer of 123 Intelligence Section was to collate and disseminate intelligence on Protestant paramilitary groups. He described how his personal contacts in Christian evangelical circles led him to meet James McCormick who raised the topic of McGrath with him.

> "The question of Tara was raised at one stage and that its leader William McGrath was a homosexual pervert. It was McCormick who actually spoke to me about this and he suggested that I should speak to Roy Garland who was ex-Tara and Garland was trying to expose Tara and McGrath."[98]

130 He then described what Roy Garland said to him in the following passage in the police statement:

> "I was introduced to Garland by McCormick and I remember the gist of what he said. Garland was afraid of McGrath and he mentioned that McGrath owed him a lot of money and also owed other people money. He told me how McGrath had recruited young boys into his circle of influence and it was partly religious and partly sexual – masturbation being the main theme – how McGrath had spoken to small boys about this subject. This occurred back in the 1960s and Garland was one of these boys. Some of it developed into homosexuality and I believe this also included Garland. I recollect Garland saying something about McGrath pursuing him after Garland got married and this was causing him distress and that it might break up his marriage."[99]

131 He went on to describe a second meeting with Roy Garland:

> "Again McGrath's homosexual tendencies, his background and all aspects of Tara were discussed. Although I can't remember if it was named I do know that Garland told me about McGrath being in charge of a boys' home. However, I do remember going to the Newtownards

98 KIN 30145.
99 KIN 30145-30146.

Road area looking for this home. I went there to get the picture in my mind as to what we were working on. I remember seeing a large detached house which I thought it was. I did not go into this house. I remember that Garland was quite outraged that McGrath should be in charge of a boys' home. I didn't feel too happy about it myself especially for potential victims and the fact that McGrath was presenting an evangelical front."[100]

132 He later described what he did to report these matters:

"I made a written report of my second meeting with Garland. I believe that this was a four side MISOR [sic], which would have been graded SECRET-UK eyes A. Because of the political implications surrounding Tara the information was only passed to Headquarters N Ireland and retained at 39 Infantry Brigade HQ. After this interview I was debriefed by the Assistant Secretary (Political) in his office at HQNI. I believe it was on a Saturday morning just prior to lunch. The Assistant Secretary, Mr Ian Cameron, was told by me the details of the interview I had with Garland. I believe that the interview I had with the Assistant Secretary was either tape recorded or his secretary, a female, took notes. When I told Mr Cameron about the homosexual involvement of various persons in Tara he reacted very strongly and said that we did not want to be involved in this kind of thing. He was abrupt to the point of being rude and instructed me to terminate my enquiries concerning Tara and in particular to get rid of another informant with whom I had been associating. This other informant was not throwing any light on the subject in question, i.e. the homosexuality. However, other events took place shortly afterwards which resulted in the Assistant Secretary reversing his decisions and allowing me to pursue the enquiry concerning Tara through the other informant. I can't remember any other specific information regarding McGrath and the boys' home. As I said I only had two meetings with Garland and it was he who gave me this information about McGrath and the home."[101]

133 There are several aspects of the account given by Brian Gemmell in this statement that are significant. First of all, although he says that he had two meetings with Roy Garland, the evidence of witness Q was that Brian Gemmell was not present at the second meeting with Roy Garland,

100 KIN 30146.
101 KIN 30146 and 30147.

and indeed the accounts given by Roy Garland of the meetings in his letter to the Inquiry of 26 September 2016 support the recollection of witness Q on this point. We are satisfied from the evidence given by witness Q that Brian Gemmell is mistaken in his belief that he took part in a second meeting with Roy Garland, and we consider it probable that what Brian Gemmell described as the information conveyed to him by Roy Garland in the second meeting came to him from the report from witness Q of his meeting with Roy Garland, or it may have been said by Roy Garland in their first meeting.

134 Secondly, Brian Gemmell refers to the four-page MISR but no such document has ever been traced, despite exhaustive efforts over the years by MI5, by the Army and, most recently, by this Inquiry to find it. So far as MI5 was concerned these efforts started within days of Brian Gemmell making his statement to D/Supt Caskey because MI5 received a report by a member of the Army Special Investigation Branch (SIB) who accompanied D/Supt Caskey during the interview.

135 On either 19 or 20 July 1982 MI5 noted that Brian Gemmell said that the MISR had a restricted circulation of three copies, and that Brian Gemmell was sure he had given one to Ian Cameron.[102] MI5 said about Garland that:

> "We have no other papers on him nor do we... know where the MISR was filed. The Army are now attempting to locate this document."[103]

136 The Caskey Phase Three investigation pursued the existence of the MISR with the Army. In a lengthy two-page police statement dated 17 December 1982, Major Saunders described in considerable detail the documents he had been able to locate in both HQNI and HQ 39 Infantry Brigade (being the brigade to which Brian Gemmell and 123 Intelligence Section were attached), and where one would expect to find either or both of the two Army copies of the MISR described by Brian Gemmell.[104] The eleven documents Major Saunders did locate can be found in full at KIN 30296 to 30341 with their RUC identification labels attached.

137 None of these documents corresponds to Brian Gemmell's description of the document he compiled as being a four-page MISR. In a further police statement of 17 December 1982, Major Saunders confirmed that

102 KIN 4133.
103 KIN 105047.
104 KIN 30156 and 30157.

none of his searches at HQNI and 39 Infantry Brigade "produced a four sided MISR relating to Roy Garland which was allegedly submitted by Captain Brian Smart Gemmell".[105]

138 Despite repeated searches over the years by the Army no such MISR has been found. In 1990 the author of the internal Ministry of Defence Rucker Report, who had access to all the surviving Ministry of Defence files, said it had not been found then.[106]

139 If, as Brian Gemmell claimed, he gave one of the three copies of the MISR to Ian Cameron then one would expect that if it exists it should be in an MI5 file, or at least we would have expected to have found a reference to it, or to it having existed at some time. No copy of any such document, and no reference to one, has been found by the Inquiry in all of the MI5 and MoD files which the Inquiry has examined.

140 However, the Inquiry has identified two documents which we believe are relevant when we try to establish whether a four-page MISR was compiled by Brian Gemmell as he has subsequently claimed. The first document was listed by Major Saunders as SWS3 in his 17 December 1982 statement.[107] As can be seen from the document, it is a MISR. It is clear from the layout of the document that a MISR was a printed form on which the necessary information was then entered. The printed form contains various spaces for information such as dates, distribution and for "Comment/Assessment/Action by Superior HQ". This MISR is dated 22 May 1975 and is said to come from a person identified as "CONCO East Belfast" located at Castlereagh. In that portion of the document in which the report should be entered it contains three typed paragraphs totalling in all four lines. In addition three handwritten lines had been added:

> "Letters appear to be to Roy Garland who was studying at Bournemouth Bible College 1963/64. The letters probably date from then".

141 In the space provided on the document for comment are two sets of initials, one of which appears to be "BSG" followed by 24/5. We infer from this that BSG means Brian Smart Gemmell and that he saw and initialled the report on 24 May. Given that the report was submitted on 22 May 1975 it seems reasonable to infer that it was 24 May 1975 that

105 KIN 30173.
106 Day 220, p.104.
107 KIN 30305-30306.

Brian Gemmell saw and initialled the report. Whether he, or someone else, added the handwritten entries, or the handwritten inscription "Tara file" which also appears in the face of the document we cannot say.

142 Although this document is a MISR and refers to Roy Garland, and is initialled by Brian Gemmell on 24 May 1975, it does not in any way correspond with Brian Gemmell's description of the MISR as being a four-page document. However, the Inquiry identified another document which, although not on a MISR printed form, in its size and content more closely corresponds to the description of the MISR by Brian Gemmell as a four-page document. This document was initially found in an SIS file. We have already referred to the document Brian Gemmell handed to two members of the SIS whom he believed at the time were members of MI5. He had a meeting on 15 October 1976 to discuss other matters with those individuals on that day as his term of duty in Northern Ireland was coming to an end. During that meeting he gave those individuals this document and the earlier document, the notes of the "one off debrief sanctioned by Ian Cameron" to which we have already referred.[108]

143 Both documents were noted on 19 October 1976 by SIS as having been obtained by Brian Gemmell from his Army files, and the other document is described as:

> "Tara – Not [sic] to File 3350/18 VOL II this paper was written by Gemmell and is based on his file on Tara".[109]

The meeting was on 15 October, and that document is dated 14 October 1976. It extends to two-and-a-half typed pages and follows the layout characteristic of other Army documents we have examined. It is very different to the scrappy, badly typed, rough notes of the debrief with Garland to which we have already referred. The 14 October 1976 document contains a detailed account of the origins of Tara, its structure, how many members it is believed to have, its geographical distribution across Northern Ireland and other such matters. As we have already observed, there is no reference whatever to Kincora or to the abuse of boys there. The only reference to McGrath is the phrase "OC-William McGrath, 5 Greenwood Ave. May be stood down due to ill health".[110] By 1976 McGrath had long since ceased to live in Greenwood Avenue, and

108 KIN 3509.
109 KIN 105030.
110 KIN 105029.

when he did live there it was at number 4 and not number 5. This, and the reference to McGrath as having possibly stood down as the OC of Tara due to ill health, suggests that the information about McGrath was of some vintage.

144 There are other indications that Brian Gemmell's recollection of the events relating to his contact with Roy Garland may not be entirely accurate. On 1 June 1990 Brian Gemmell gave an interview which was carried as part of a BBC *Public Eye* programme under the title "Kincora – The MI5 Connection", although the person speaking in the relevant part of the programme appears under the pseudonym "James" we are satisfied from the content of the discussion that James was Brian Gemmell. During the programme the following exchange between Brian Gemmell and the interviewer takes place:

"Question:	Does Roy Garland mention Kincora?
(Brian Gemmell):	Yes he tells me that at that stage McGrath has a position in Kincora and that Kincora is a boys' home, he's very concerned about that.
Question:	Does he mention Kincora by name or does he just say boys' home?
(Brian Gemmell):	I believe it's by name, I can't remember exactly but I believe it's by name. He doesn't know exactly what is going on but we are putting 2 and 2 together and making 4 when history shows that we should have made 6.
Question:	Does he say that he believes that boys or young people are being abused in the boys' home?
(Brian Gemmell):	I think he says he believes it but he doesn't know it to be true.
Question:	No evidence?
(Brian Gemmell):	I do not think he has been into the boys' home, put it that way.
Question:	Are you concerned at the allegation?
(Brian Gemmell):	I am concerned at the allegation. Yes.
Question:	Did you believe him?
(Brian Gemmell):	I believed that Mr Garland believes he is telling me the truth. It obviously has to be investigated and enquired into."

The programme continues with the statement that:

> "James wrote a report of his meeting and sent it up to his Army superiors as a matter of routine. He says it was then passed to MI5 who shared the same building at Army Head Quarters".[111]

145 Contrary to what he says in that extract from the *Public Eye* interview, in none of his contemporary records does Brian Gemmell refer to Kincora or to McGrath abusing boys there. By 1982 when he made his statement to D/Supt Caskey, McGrath and the others in Kincora had been exposed, convicted and sentenced, and the events relating to Kincora were subject to widespread publicity over the previous two years or so before he made his police statement in July 1982. Whilst Brian Gemmell correctly viewed McGrath as "an evil man", "a sexual deviant who undoubtedly corrupted the boys in his care", as the SIB officer present at the police interview appears to have reported afterwards,[112] if, as he said to the *Belfast Telegraph* in 2014, Mr McCormick had told him there were three abusers in Kincora it is extremely hard to see why he would not have remembered that, would not have thought that it was plainly relevant to what he was being asked about, and said it in his police statement. No reference to such an assertion by Mr McCormick appears in any of the contemporary documents written by Brian Gemmell.

146 A further indication that Brian Gemmell's recollection in subsequent years may not be entirely reliable can be seen from his reference in the *Belfast Telegraph* article to his assertion that he severed his relationship with the Intelligence Services when he left the Army in 1976. He is quoted as saying:

> "It was a profession in which lies and cover-up were tools of the trade. As a Christian, I could not make that separation between private and professional morality".[113]

We observe that whilst that appears to be Mr Gemmell's view today, by the end of his military service he renewed his attempt to join MI5. He had a meeting about that with MI5 Officers on 7 September 1976,[114] and on 23 November 1976, a few weeks after he handed over the documents on 15 October 1976 he was interviewed by MI5 but was

111 KIN 3549.
112 KIN 105045.
113 KIN 3545.
114 KIN 4015 and 105036.

rejected as a candidate for that service.[115] He appears to have been applying for continuing work in the intelligence field on a permanent basis by working for the Security Service at the end of two years working in Military Intelligence in Northern Ireland, and that suggests to us that his present views as to the immorality of such work do not represent his views at the end of his military service in Northern Ireland in 1976.

147 The position is that since July 1982 no one has been able to find the MISR which Brian Gemmell said at that time he wrote and gave one copy of to Ian Cameron. The context of the account he gave in his 1982 police statement as to when he did that suggests that it must have been written in 1975 when the contemporary records show that he was in contact with Roy Garland, and indeed as Roy Garland himself says. We consider it probable that when Brian Gemmell compiled the October 1976 Tara Report in which he referred to McGrath, but did not refer to Kincora, he was relying on his 1975 notes of his meeting with Roy Garland, as well as possibly relying on other material in his Army file.

148 No document has been found corresponding to his description of the document he prepared as a four-page MISR. The MISR which he signed on 24 May 1975 cannot be that document because it has only a few lines of typed and hand written information on it. However, the two-and-a-half page 14 October 1976 document, although it is not on a MISR form, and is two-and-a-half and not four pages in length, corresponds much more closely in content with what would be expected to be in a MISR dealing with Tara.

149 In his statement to the Inquiry, Dennis referred to discussions he had with Brian Gemmell.

> "I later had several discussions with Captain Gemmell at HQ 39 Bde during one of which he described how the report had been disseminated up to HQNI, in the normal way, but that a strongly worded rebuke had come back from them to drop the matter immediately – whether this rebuke was in written or verbal form, or by whom, I do not know. I do know from other, later, discussions with him that he continued privately to pursue the matter of TARA and reports of the abuse of boys at the Kincora premises. Capt Gemmell eventually left the Province, I believe prematurely, and I later heard that he had resigned his commission."[116]

115 KIN 4062 and 105031.
116 KIN 190219.

150 It is unclear from this whether Dennis had these discussions with Brian Gemmell before Brian Gemmell left the Province, or subsequently, although the implication is that the discussions were before Brian Gemmell left Northern Ireland. However, in his 1982 police statement Brian Gemmell made no reference to his having known that boys were being abused in Kincora, his belief was there were potential victims because McGrath was in charge of a boys' home, and that was based on what Roy Garland had told him of his experiences with McGrath years before McGrath worked at Kincora. We consider it probable that Dennis's memory of these discussions has been tainted by what he may have heard about Kincora in later years; we therefore prefer what Brian Gemmell said to the police in 1982.

151 It is clear from witness Q's evidence that from the military perspective the object of speaking to Roy Garland in 1975 was to obtain information about Tara. We have referred to other aspects of Brian Gemmell's recollection of what he did or did not say in 1975, and we consider that he was mistaken in 1982 when he said that he prepared three copies of a four-page MISR, and gave one copy to Ian Cameron. We are satisfied that he has mistakenly conflated the short May 1975 MISR and the 14 October 1976 document into his recollection of a single MISR. It is easy to see how this could have happened. By the time he made his July 1982 statement he was no longer in the Army and therefore did not have access to the files to refresh his memory or check his recollection. In addition, the events he described happened between five-and-a-half and nearly seven years before. In his reply to the Inquiry Warning Letter Mr Gemmell informed us that although he maintained there were numerous inaccuracies and unjustified assumptions in that portion of the Draft Report provided to him by the Inquiry with the Warning Letter he did not wish to respond to the Warning Letter.

152 In the 1 June 1990 *Public Eye* programme Brian Gemmell referred to other matters which we have considered. In particular he described the reaction of Ian Cameron to his discussions with Roy Garland. These were investigated by D/Supt Caskey in 1982 and 1983 as part of the Caskey Phase Three investigations, and it is therefore more convenient to examine Ian Cameron's version of those discussions in the context of the unsuccessful efforts of D/Supt Caskey to interview Ian Cameron in person at that time. At this point we therefore turn to examine two other matters which may have a bearing on the issues we have to consider. The first relates to MI5's attitude towards John McKeague, and the second concerns MI5's attitude to Tara in 1977.

MI5 and John McKeague's homosexuality

153 In the 1 June 1980 *Public Eye* programme Brian Gemmell referred to a meeting he said he had with two MI5 officers in London when there was a discussion about the chances of using John McKeague, who was a prominent suspected loyalist terrorist figure of the time, as an informant. McKeague was widely believed to be the founder of the proscribed loyalist terrorist organisation called the Red Hand Commando, and to be homosexual. He was murdered in 1982.

154 The transcript of the programme to which we have earlier referred contains the following exchange between the interviewer and Brian Gemmell:

> "(Brian Gemmell): According to them they have some compromising film of a homosexual nature of John McKeague which they wonder could it be used to make Mr McKeague co-operative as an informant.
>
> (Interviewer): Are you sure they are suggesting or asking your advice on using Mr McKeague's alleged homosexuality as a way of blackmailing him into co-operating with the Security Service?
>
> (Brian Gemmell): I don't think that the word blackmail was actually ever used in our discussions. Enticing, encouraging, putting pressure on; I'm quite certain about that.
>
> (Interviewer): Does it surprise you when you are asked that kind of question involving the alleged homosexuality of a person?
>
> (Brian Gemmell): Not really, I am more surprised at the protestations that intelligence forces do not deal with a thing like that."

155 The response of MI5 to this is contained in the statement of Officer 9004 of 20 June 2016 at paragraph 72-81.[117] He said the following at paragraph 74:

> "We have examined this allegation and established that MI5 had no compromising film of McKeague and never made any attempt to blackmail him. However, one MI5 officer did put forward an

117 KIN 4068 and 4069.

operational proposal (which was never endorsed) which involved using McKeague's homosexual activities in London in an attempt to recruit him. We describe the chronology of events below."

156 Officer 9004 went on to describe how McKeague was the subject of surveillance during a visit to London in June 1976 when he was suspected of being part of a UVF arms procurement operation. Photographs were taken of him in public places which suggested to those conducting a surveillance that McKeague had contact with young men to establish homosexual assignations. On 7 September 1976 Gemmell had an informal lunch meeting with an MI5 officer. There is no record of what was said, but we consider it probable this is the meeting to which Brian Gemmell was referring in his Public Eye comments, although he did meet two MI5 officers in London on 10 May 1976 in connection with the handling of an agent unrelated to McKeague.[118]

157 Officer 9004 said that there was a proposal in November 1976 by the MI5 officer with whom Brian Gemmell had lunch in September that "serious consideration should be given to using [McKeague's] homosexual tendencies to recruit him".[119] Officer 9004 related that although the proposal was examined by other officers, including management, it was not endorsed. He also said that MI5 neither took nor possessed any compromising photographs of McKeague.

158 That such a suggestion was made in November 1976 renders it quite possible that there may have been some discussions between MI5 officers and Brian Gemmell of the type Brian Gemmell described in the *Public Eye* programme. The Inquiry examined the original records relating to this proposal and to the meetings between Brian Gemmell and MI5 in the Autumn of 1976. These records support the account given to the Inquiry by Officer 9004. We are satisfied there was a discussion of a general nature by an MI5 officer with Brian Gemmell, a discussion which probably took place at the lunch in September 1976, when the possibility of exploiting McKeague's homosexuality was discussed. We are satisfied that although that possibility was considered and examined by MI5 it never progressed to the stage of being more than a proposal. We are also satisfied that no photographs were taken of a compromising nature.

118 KIN 4068.
119 KIN 4069.

159 As we have already pointed out, by September 1976 Brian Gemmell had served the best part of two years in an intelligence capacity in Northern Ireland. His visit to London on 7 September 1976 was because he was pursuing his earlier ambition to join MI5, and he had a meeting for that purpose that afternoon. The discussion about the possibility of exploiting McKeague's homosexuality does not appear to have deterred him from pursuing his application to join MI5 at that stage because he was interviewed for that purpose in November 1976 but was rejected.[120]

MI5 and Tara in 1977

160 On 19 October 1976 MI5 received from SIS a copy of the lengthy intelligence report on Tara prepared at 3 Brigade dated 28 January 1976.[121] The full report can be found at KIN 30297–30302. It runs to six pages and gives considerable detail about what was known about Tara, its origins, membership, structures and objectives. The information was said to have come from three contacts. In that portion relating to McGrath appears the following paragraph:

> "McGrath is a homosexual and makes a practice of seducing promising young men".[122]

Having given a number of names, in the next paragraph there are references to intelligence which gave "distinct impressions that McGrath was somehow associated with communism". At the end of paragraph 7 there appears the following:

> "McGrath is currently described from the 1975 Belfast Street Directory as a Welfare Officer. He is thought to be running some form of boys' home".[123]

161 It will be apparent from the document that whilst it describes McGrath as a homosexual "who makes a practice of seducing promising young men", it is clear from the names and descriptions of the "young men" then referred to that they were young men active in politics and not residents of Kincora. Whilst there is a reference to McGrath being "thought to be running some form of boys' home" there is no reference to Kincora as such, and the reference is clearly incidental to a discussion of his financial position and means of support. We consider it significant that

120 KIN 4062.
121 KIN 3508.
122 KIN 30298.
123 KIN 30298.

there is no reference of any sort in this document to McGrath engaging in the seduction of, or sexual activity with, residents of Kincora.

162 The receipt of this document from SIS on 19 October 1976 appears to have prompted MI5 to pay further attention to Tara, because on 31 January 1977 an SIS officer in London referred to the 28 January 1976 report, and explained that MI5 have asked if "the source mentioned in the letter could be retasked for further information".[124] An intelligence officer in Northern Ireland replied on 2 February 1977 by saying that they did not have a copy of the letter, nor did they know who the source was.[125] It is clear that the interest of the security services at this stage came about because they wished to explore what was described as "RIS [Russian Intelligence Service] involvement with the Protestant Extremists in Northern Ireland".[126]

163 Following further exchanges about Tara, on 11 February 1977 an SIS officer in London wrote:

> "We look forward to learning more about the orbat [sic] and finances of this organisation. When we have such information we may be able to put Tara in its proper perspective".

The writer then made two requests to intelligence staff in Northern Ireland and to MI5, one of which was:

> "Would the Tara recruiting campaign offer... a loophole to penetrate Tara, if we consider it a worthwhile target".[127]

164 We regard this document as being of considerable significance. So far the documents and events we have examined show that both MI5 and SIS were interested in Tara and sought to obtain information about it. One of the details MI5 had attempted to establish from June 1971 onwards was who was the person described as McGrath, and it appears to have taken until 1973 before that was fully accomplished. Thereafter there are occasional documents relating to Tara and McGrath. The events from 1975 and 1976 involving Brian Gemmell strongly suggest that by that stage MI5, SIS and the Army were still gathering such information as they could about Tara, including confirmation that McGrath remained the commanding officer. It is in that context that the references to McGrath that we have examined occur.

124 KIN 105032.
125 KIN 105204.
126 KIN 105205.
127 KIN 105208.

165 On 15 February 1977 SIS asked MI5 if Tara was a worthwhile target to penetrate. If, as has been suggested by various journalists and commentators, McGrath had been an agent of SIS for many years, or was an agent of MI5, and in either event was controlled by either or both agencies, it is extremely surprising that all the contemporary records from MI5 and SIS show that both had devoted much effort to finding out who McGrath was, and as much as they could about Tara. That they were doing so suggests that he was not an agent of either agency. What would be the point of considering penetrating Tara in February 1977 if, as alleged, he was an agent of either agency? On the other hand, if he were not an agent, then all the efforts that were made to gather the information that we have examined are entirely consistent with, and indicative of, the fact that he was not such an agent of either agency. Later in this chapter we examine other material that bears on this question.

The interaction between Brian Gemmell and Ian Cameron in 1976

166 We have already quoted what Brian Gemmell said to the police in his 1982 statement about the occasions on which he spoke to Roy Garland in 1975, and what he claimed was Ian Cameron's response. We also refer to this in the context of the Public Eye programme when he described being summoned to see "the senior MI5 officer", meaning Ian Cameron.

> "I can't honestly say I was expecting three gold stars but I went up feeling fairly positive, expecting a normal meeting".[128]

In the 6 August 2014 Belfast Telegraph article he is quoted as saying:

> "Ian Cameron was very much a father figure to me at the time, ...I was in my mid-20s and he was in his early 60s. He was a very nice chap, but he reacted very strongly. He told me that MI5 did not concern itself with what homosexuals did and he ordered me to stop using an agent I had within Tara..."[129]

167 In seeking to establish at this remove many years later what Ian Cameron said to Brian Gemmell, and his response to the information Brian Gemmell gave him after his initial meeting with Roy Garland, it

128 KIN 3549.
129 KIN 3545.

is necessary to consider what Ian Cameron said about this when D/Supt Caskey pursued this issue as part of the Caskey Phase Three investigations. We have already explained why we believe there was only one meeting between Gemmell and Garland, and because witness Q made clear to us that after Brian Gemmell and he spoke to Roy Garland at Mr McCormick's house, the intended second meeting with Roy Garland at Thiepval was cancelled. However, it was reinstated when Brian Gemmell was instructed that there could be a second meeting, but the focus was to be on Protestant extremism, meaning Tara, and not the sexual matters relating to McGrath that Roy Garland had described at the first meeting.

168 There is no contemporary reference to discussions between Brian Gemmell and Ian Cameron, apart from the note for file that Gemmell and witness Q were told they could interview Garland,[130] an instruction given after the meeting with Jim McCormick. A file note of 9 June 1975 by Ian Cameron referring to instructions he gave Brian Gemmell to break off contact, did not refer to contact with Roy Garland, but to contact with an agent whose identity is known to the Inquiry. Brian Gemmell acknowledged that there was another informant in his 1982 police statement.[131] It is likely that Brian Gemmell mistakenly conflated the separate sets of instructions when he gave his interview with the *Belfast Telegraph* of 6 August 2014 to which we have referred. This conflation may account for Ian Cameron's answer to Q10 of the Caskey 30 questions when it was recorded that;

> "…he does not accept that he reversed his decision but is not sure what the police are getting at".[132]

The evidence of Officer 9347

169 Before turning to consider other matters which may bear on the issue of what Brian Gemmell said to Ian Cameron, or what Ian Cameron said to Brian Gemmell, it is convenient to consider the evidence of Officer 9347, who gave evidence to the Inquiry on Day 221. He is a retired officer of the Security Service who served as the ASP at Thiepval between 1981 and 1983. Although his period as ASP was some years after Ian Cameron, he knew Ian Cameron. Officer 9347 explained that because

130 KIN 4134.
131 KIN 30146.
132 KIN 105059.

he was the ASP in post in 1982 he became involved in the response of the Intelligence Services to the Caskey Phase Three investigation. More specifically, he was aware of that part of it which involved the questioning of Brian Gemmell by D/Supt Caskey. We have already explained that this part of the investigation was dealt with in a separate secret report to the DPP which we call Caskey Phase Three. As part of that he prepared the 4-page report of 19/20 July 1982 to which we have already referred and which is to be found at KIN 105044-KIN 105047.

170 Officer 9347 explained that while he cannot now remember the documents on which he based this report, and particularly those which he must have consulted when preparing paragraph 8, he did have access to those documents at the time. We are satisfied that those documents were held on a local file in Thiepval, which has now been destroyed.[133] We are therefore reliant on Officer 9347's evidence of what he must have seen in 1982 when he wrote paragraph 8. It is in the following terms.

> "Gemmel's [sic] interview with McCormick on 25 March 1975 (which included a request for authority to approach Garland) is filed on [codeword] PF. Responding to this request [MI5 Officer] wrote a note for file recording that Gemmel [sic] and [MOD Officer Q] were told on 4 April 1975 by ASP and [staff des] that quote it was in order for Garland to be interviewed on the strict undzerstanding [sic] that the overt and clearly expressed reason was a requirement for information on Tara. It was emphasised that the Army had no interest in investigation of deviant sexual activities or religious aspects of the group which was solely the function of a specialist section of the RUC. Therefore this discussion should be steered away from this type of issue. Anything Garland might say about peresonalities [sic] involving particularly [codeword's] would be of interest."[134]

171 In effect, Officer 9347's evidence was that in 1982 the file on which he based paragraph 8 enabled him to say that in 1975 Ian Cameron recorded that he had instructed Brian Gemmell that (1) the reason for the interview with Roy Garland was to gather information on Tara; (2) the Army was not interested in investigating deviant sexual activities or religious aspects of Tara; because (3) those were solely the function of a

133 Day 221, p.103 and KIN 4011.
134 KIN 105046 and 105047.

specialist section of the RUC. What was meant by "a specialist section of the RUC" is not clear. At that time the RUC did not have a specialist CARE (Child Abuse and Rape Enquiry) Unit, and so the reference to a "specialist section" may have referred to RUC Special Branch.

172 Paragraph 8 clearly contained a direct quote from another document, as indicated by the standard MI5 usage in such telegrams of the words quote and unquote rather than placing a quotation in inadverted commas. We see no reason not to accept the evidence of Officer 9347 that paragraph 8 was an accurate record of what he saw in the file in 1982. That is relevant when we come to consider the interaction between Brian Gemmell and Ian Cameron in 1976, because the use in paragraph 8 of a direct quotation from a contemporary document which no longer exists provides support for Ian Cameron's 1982 account of these events. As we shall see, by that time he had retired from MI5.

Ian Cameron's account of these events in 1982

173 Ian Cameron died some years ago, and so we are dependent upon his answers to questions posed to him during the Caskey Phase Three investigations as recorded at the time by the legal adviser of MI5. We shall examine why Ian Cameron was not interviewed in person by D/Supt Caskey in the next part of this chapter. At this stage we concentrate on what Ian Cameron is recorded as saying in answer to the list of 30 questions drawn up by D/Supt Caskey in order to establish what Ian Cameron's responses were to what Brian Gemmell had said about Ian Cameron's approach to Brian Gemmell's contacts with Roy Garland.

174 The 30 questions are to be found at KIN 105055-105058, and the answers are set out KIN 105059 and 105060. When considering the answers it has to be borne in mind throughout that the answers do not purport to be the actual words of Ian Cameron, but are the answers as recorded in the third person by Bernard Sheldon, the former MI5 legal adviser, following a conversation he held with Ian Cameron on 1 November 1982 when Ian Cameron was about to go abroad. By then Ian Cameron had retired from the Security Service.[135]

175 For the purposes of the present issue as to the instructions Ian Cameron gave Brian Gemmell, and how Ian Cameron reacted, the relevant answers are to questions 6 to 17 inclusive. These indicate that in

135 KIN 105063

November 1982, some six-and-half years after the events (that period being calculated on the basis that the interviews with Roy Garland were in the spring or early summer of 1975) Ian Cameron's recollections can be said to be as follows:

1 He received information from Brian Gemmell that McGrath was a homosexual.

2 He had no recollection of any details, or of any reference to a boys' home.

3 He did not accept that he reversed his decision.

4 In response to Brian Gemmell's account to the police that he, Ian Cameron, reacted very strongly when told of the homosexual involvement of various persons in Tara he did not comment.

5 He agreed that he would have told Brian Gemmell not to pursue the allegations of homosexuality, and would have told him that the Army should not handle investigations in this field.

176 As we are satisfied from witness Q's evidence that Ian Cameron decided that there should not be a second interview of Roy Garland, and then reversed that decision, we are satisfied Ian Cameron was mistaken when he said that he did not reverse his decision. Ian Cameron agreed with Brian Gemmell that Brian Gemmell told him McGrath was homosexual and that he, Ian Cameron, told Brian Gemmell not to pursue the allegation of homosexuality, meaning McGrath's homosexuality, because the Army should not carry out investigations in that field. However, Ian Cameron did not respond to the assertion that he had reacted very strongly when Brian Gemmell told him about the homosexual involvement of various people in Tara. We consider that his failure to comment on the assertion that he had reacted "very strongly" means that we should infer that he did not dispute that assertion.

177 It is also relevant that he accepted he told Brian Gemmell not to pursue McGrath's homosexuality because this was not a matter for the Army. Ian Cameron did not address the assertion that he told Brian Gemmell to terminate his enquiries concerning Tara. The file note of 4 April 1975 by an MI5 officer who had been present at the meeting with Gemmell and witness Q made it clear that the Army's only interest in permitting Brian Gemmell to speak to Roy Garland was to obtain information about Tara, and that Brian Gemmell should not pursue the allegation of homosexuality, which in this context clearly meant Garland's allegations about McGrath's homosexuality.

Whether he put it in such stark terms as Brian Gemmell alleged or not, we are satisfied that the effective result was that Ian Cameron took the position that Roy Garland's allegations about McGrath were not matters for the Army.

178 Ian Cameron's response to the effect that he had no recollection of any reference to a boys' home, does not necessarily mean that a boys' home was not mentioned. We are satisfied that while Brian Gemmell did tell Ian Cameron about McGrath's homosexuality, and that Ian Cameron may have reacted strongly in order to emphasise that this was not a suitable topic to be pursued, the effective result was that Roy Garland was to be interviewed to see if he had anything useful to say about Tara and not about anything else.

D/Supt Caskey, Ian Cameron and MI5

179 We have referred to the answers given by Ian Cameron in November 1982 to the 30 questions prepared by D/Supt Caskey, and at this stage we examine the circumstances relating to the preparation of those questions, how they were answered, and whether the answers were made available to the RUC or the Director of Public Prosecutions, Sir Barry Shaw QC. The background to those circumstances was that, as part of the Caskey Phase Two investigation into whether there had been a cover-up which might amount to criminal offences by anyone who may have had knowledge about sexual offences committed against residents of Kincora, D/Supt Caskey agreed with the DPP that he would submit a separate secret report on that part of the investigation that related to the Intelligence Services. We refer to this report, and the related enquiries, as Caskey Phase Three.

180 Sir John Hermon, the Chief Constable of the RUC had invited Sir George Terry to investigate both the way in which the RUC carried out the Caskey Phase One investigation, which led to the conviction of McGrath and others, and to oversee the Caskey Phase Two investigation at the same time. The Caskey Phase Three investigation was therefore in effect a separate sub-part of the Caskey Phase Two investigation which was being carried out by the RUC, but subject to the oversight of Sir George Terry. That is relevant when we come to examine Sir George Terry's part in the events we now consider.

181 By 1 July 1982 MI5 were aware that D/Supt Caskey wished to interview Brian Gemmell, and MI5 were concerned that the interview with Gemmell might result in information relating to intelligence matters being disclosed

to the RUC, and subsequently disclosed in any public inquiry that might follow the RUC investigation.[136] A meeting took place between an MI5 officer, the MI5 officer who was the DCI Rep Knock (i.e. the MI5 officer attached to RUC headquarters) and D/Supt Caskey during which the MI5 representatives "emphasised that our sole concern was to ensure that intelligence matters did not get an airing in public".[137]

182 After D/Supt Caskey's interview with Brian Gemmell on 18 July 1982 the Army Special Investigation Branch Officer present reported on the content of the interview, and we have already referred to that report when examining what Brian Gemmell said in the statement. MI5 anticipated that D/Supt Caskey would then seek to interview Ian Cameron about the allegations Brian Gemmell made to him about the nature of Ian Cameron's instructions to him. A meeting took place at RUC headquarters on 4 August 1982 which was the subject of an MI5 report of 5 August 1982. During the meeting MI5 explained their position to Caskey about Ian Cameron being interviewed in this way.

> "…I explained your principle – that no serving or former member of the Security Service should be interviewed by the Police".[138]

183 The MI5 note also explains a number of matters about which D/Supt Caskey wished to interview Ian Cameron, as well as the suggestion as to how the information might be obtained.

> "(Letter three) Caskey made a number of points:
>
> A. One of the aspects of the enquiry that he is pursuing is that "military intelligence" was aware that McGrath was committing criminal offences but they concealed this or did not report it for their own reasons: this, if true was a criminal offence. Garland has alleged this and Wallace has hinted at it to Caskey."[139]
>
> "G. Caskey would be prepared to meet LA [legal advisor], explain to him what questions he wanted Cameron to answer and then receive a written statement drawn up by LA and Cameron. Caskey returns from leave on 23 August and would like to meet LA soon afterwards if this idea is accepted."[140]

136 KIN 105039.
137 KIN 105043.
138 KIN 105049.
139 KIN 105049.
140 KIN 105050.

184 It is clear that throughout the autumn MI5 were still extremely concerned about the prospect of Ian Cameron being interviewed by the RUC. Their legal adviser, Bernard Sheldon, raised this concern with the Attorney General and the DPP on a number of occasions. A memorandum from Bernard Sheldon of 1 October 1982 refers to his having at least two meetings with the Attorney General, and the DPP was present at one of them. Although the date of the meeting is not given, it appears to have been before another meeting between the Attorney General and DPP on 24 September 1982 at which Bernard Sheldon does not appear to have been present, but about which he was informed by a senior official in the Attorney General's office. A full memorandum can be found at KIN 105052 and 105053. In the memorandum Bernard Sheldon made a number of points to the Attorney General and DPP:

1 He confirmed that the RUC wished to interview Ian Cameron.

2 He explained that MI5 had spoken to Ian Cameron and set out in brief terms what Ian Cameron had said in answer to the assertions by Brian Gemmell.

3 He explained why MI5 were reluctant to allow Ian Cameron to be interviewed.

> "I said that this had been reported to the RUC but we had been unwilling to allow Cameron to make a formal statement. He had no personal knowledge which was relevant to any alleged offence and it also appeared that the RUC thought that they were collecting evidence for an enquiry as well as investigating criminal offences. If there were other factors which had not been declared to us, we would of course reconsider the position and equally if there should be a public enquiry we would discuss the handing of any relevant information which we might have (and I thought we had none) with those responsible for setting it up. We were not, however, willing to create statements which did not appear to assist in the criminal investigation and which might touch upon the organisation of intelligence in Northern Ireland – particularly as we had no idea who would have access to the statements or whether their creation might not automatically lead to their disclosure in the event of an enquiry."[141]

141 KIN 105052.

185 It is significant that Bernard Sheldon recorded the Attorney General as commenting that any information which Cameron could give:

> "would appear to be 'hearsay upon hearsay'".[142]

The DPP's response appears to have been more non-committal, as he was recorded as saying that this problem had not been reported to him and he would ascertain the position.

186 It appears from the memorandum that the Attorney General and the DPP had discussed the request beforehand and the DPP's view was that he needed to know whether Cameron had made a report to people in the Northern Ireland Office where there were some suspects. Their failure to take action in that event might be significant. It would seem that that discussion must have taken place after the earlier meeting referred to in the memorandum. A suggestion was then made by James Nursaw, who was the Attorney General's legal secretary at the time, that the police should set out a clear list of questions to which they wished to have answers. Bernard Sheldon recorded that his response was:

> "I said that we would consider any such request on its merits but the police would also have to come clean with us about their objectives. If there was a real as opposed to a fanciful problem we would certainly wish to find ways of helping".[143]

187 It would seem that that may have been the origin of, or at least played a part in, the genesis of the list of 30 questions, because on 11 October 1982 D/Supt Caskey submitted the 30 questions to ACC Whiteside. As can be seen from the opening paragraphs of the memorandum to the ACC, D/Supt Caskey's view now was that there should be an interview of Ian Cameron by the RUC.

> "It is essential to the Kincora Enquiry that Mr Ian Cameron is interviewed by the Royal Ulster Constabulary in relation to intelligence concerning Kincora Boys' Hostel allegedly passed to him by Military Intelligence Officers.
>
> I hereby submit a list of questions to be put to Mr Cameron.
>
> It will be necessary in the first instance to ask Mr Cameron to provide such personal details as full name, age, occupation, address or contact address.

142 KIN 105052.
143 KIN 105053.

> Whilst it is intended to adhere to the list of questions now supplied, answers to these questions may demand a follow-up question or questions:"[144]

188 There can be no doubt that the request was for a face-to-face interview with Ian Cameron by the RUC; during that interview they would ask him the 30 questions but there may well have been other matters that would emerge which would demand a follow-up question or questions.

189 The list of questions was forwarded by ACC Whiteside to the Northern Ireland Office the same day. The recipient of the letter had had a conversation with the Chief Constable and the RUC position was set out in clear and unmistakable terms.

> "The questions are all relevant and clearly define the area of police interest. It may be that if Mr Cameron answers certain questions in a certain way further unscripted questions may have to be asked in order to clarify some points so raised. I mention this lest there would be any misunderstanding about unscripted questions being asked."[145]

190 The documents we have examined show that after that memorandum from the ACC, MI5 maintained its position that it was not prepared to make Ian Cameron available to the RUC for interview. The reasons for this were set out at some length by Bernard Sheldon in a note to the Director General of MI5 dated 3 November 1982.

> "2. I have made it plain to Nursaw and to Barry Shaw and the Attorney General that our unwillingness to authorise Cameron to give a statement should not be taken as meaning that we have anything to hide in connection with homosexual offences or that we wish to be obstructive. We believe that we have nothing to contribute to any criminal investigation and are unwilling to allow statements to be taken from Cameron which will disclose intelligence arrangements to those who have no need to know. We are conscious that once a statement has been taken we will have no control over who has access to it and that its very existence could cause problems if an enquiry is ordered. If an enquiry is ordered, we would of course be in touch with those responsible for arranging evidence for it (this would normally be the Treasury Solicitors) if it was thought that we

144 KIN 105055.
145 KIN 105054.

had some contribution to make. Nursaw has suggested that it might be sensible to explain the position informally to the Chief Constable and to stress that we have no knowledge of criminal offences."[146]

191 Bernard Sheldon subsequently spoke to the Chief Constable of the RUC on 11 November 1982 explaining why MI5 did not believe that Ian Cameron could deal with the questions because he was retired and remained subject to the provisions of the Official Secrets Act.[147] D/Supt Caskey pursued his investigations and traced and took statements from Army personnel in Germany. Bernard Sheldon then went to Lewes to the headquarters of the Sussex Constabulary where he explained MI5's position to Sir George Terry. Having outlined in considerable detail MI5's position, and the various meetings that had taken place, in the course of the memorandum he referred to:

"f. the list of questions prepared by the RUC which they wished to put to Cameron. These confirmed our fears that, if permitted, they would lead to an unacceptable identification of UK Intelligence Officers and their functions,"[148]

192 The RUC position remained that they wished to interview Ian Cameron, and when no such interview was forthcoming by 24 February 1983 ACC Whiteside again wrote to the NIO. His memorandum makes it abundantly clear that Ian Cameron was not being made available for interview, and that no replies to the 30 questions had been communicated to the RUC. The letter made it clear that the RUC wanted an interview with Cameron, or at least wished to obtain a statement from him.[149]

193 Although Ian Cameron was by now retired, he remained subject to the provisions of the Official Secrets Act and therefore required authorisation from MI5 in order to discuss anything relating to his duties as the Assistant Secretary (Political). We are satisfied that the documents to which we have referred make it abundantly clear that MI5 were not prepared to allow him to be interviewed under any circumstances because, as it was put on 5 August 1982, it was their "principle that no serving or former member of the Security Service should be interviewed by the police". That position was maintained throughout by MI5 despite repeated formal requests by the RUC that Ian Cameron should be made

146 KIN 105061.
147 KIN 105063.
148 KIN 105066.
149 KIN 100015.

available for interview. Ian Cameron was never made available for interview by the RUC, nor was any statement prepared by him to the RUC in which he answered the 30 questions, nor is there any record to show that the text of his answers as recorded by Bernard Sheldon were ever communicated to the RUC.

194 We appreciate the concern of MI5 that intelligence matters might be exposed, perhaps inadvertently, by an interview with Ian Cameron. However, this could have been dealt with by an RUC officer of higher rank and experience, such as a Detective Chief Superintendent or even an Assistant Chief Constable, carrying out the interview in the presence of an MI5 Officer of suitable standing. That such a high ranking officer would conduct an interview was by no means unknown at this stage, certainly in the RUC and indeed Sir George Terry himself took part in an interview with the Rev Ian Paisley during the course of his enquiries. If there were arguments about whether irrelevant intelligence matters were being explored, then those questions could be considered as necessary by either the DPP personally or the Attorney General personally. We consider that MI5's "principle that no serving or former Officer of the Security agencies should be interviewed by the police" in the course of a criminal investigation was wholly unjustified. We are satisfied that in the ultimate analysis it was for the RUC and not for MI5 to decide what was relevant to that criminal investigation. We criticise MI5 for consistently obstructing a proper line of enquiry by the RUC by their refusal to allow the RUC to interview Ian Cameron, and by their refusal to authorise Ian Cameron to provide a written statement answering the 30 questions. We are also satisfied that MI5 did not communicate the full details of the answers to the RUC that Ian Cameron gave to Bernard Sheldon on 1 November 1982. We noted that in its response to the Inquiry Warning Letter, MI5 did not accept that it had obstructed the RUC in its efforts to interview Ian Cameron.

195 Whilst we accept that MI5 were entitled to make their concerns known to the Chief Constable of the RUC, the DPP, and to the Attorney General about the implications of the questioning of Ian Cameron, we have reservations about the frequency of these representations. We are satisfied that the approach to Sir George Terry was made so that he could put pressure on the RUC not to pursue this line of enquiry.

196 That MI5 felt it could approach Sir George Terry to enlist his support in MI5's efforts to prevent RUC officers interviewing Ian Cameron demonstrated

a weakness in the arrangement whereby Sir George had been invited to oversee the Caskey Phase Two investigation, and therefore the associated secret Phase Three investigation as well. It is unclear to us what oversight meant in practice. It is clear that Sir George was not directing the RUC investigation because that remained very firmly under the control of the RUC as is clear from the approaches by MI5 to Sir John Hermon, the correspondence between ACC Whiteside and the NIO, and that it was the RUC who submitted D/Supt Caskey's report to the DPP. If Sir George was expected to give advice during the investigation, how was that to be done? Was it just that he would offer advice (but not directions) if his advice was sought by Sir John Hermon or his subordinates, or was Sir George free to offer unsolicited advice to D/Supt Caskey and his team? We were struck by the lack of clarity in what oversight meant in practice.

197 We do not accept that it was proper for MI5 to approach Sir George Terry in an attempt to enlist his support. This was an RUC investigation, and although it was being overseen by Sir George we do not consider that that gave him the right to interfere in the way that it was being conducted. It was of course open to him to offer advice to Sir John Hermon if Sir George thought that was necessary or if Sir John Hermon sought that advice.

The DPP and Ian Cameron's responses to the 30 questions

198 In order to ascertain whether Sir Barry Shaw received and considered the responses to the 30 questions made by Ian Cameron and recorded by Bernard Sheldon we are dependent upon MI5 records to which we have referred. This is because there do not appear to be any surviving records held by the Public Prosecution Service in Northern Ireland relating to meetings held between Sir Barry Shaw and the Attorney General in relation to the Caskey Phase Three investigation. When we asked the Attorney General's Office in London to produce any papers they held regarding these meetings we were informed that the files they held in relation to Kincora had been destroyed in 2004. In response to the Inquiry Warning Letter the Attorney General's Office informed us a mistake had been made (for which they apologised) and that the relevant file was destroyed in 2009. We criticise the destruction of files relating to Kincora in view of the persistent allegations that there had been over many years about wrongdoing at Kincora.

199 The original files relating to the decision of the DPP to issue a direction on 17 May 1983 that there should be no prosecution in respect of the matters considered in the Caskey Phase Three secret report have survived, and the Inquiry has examined them. We have also had the benefit of a helpful written statement from Mr Roy Junkin, a former Deputy Director of Public Prosecutions in Northern Ireland who was an Assistant Director of Public Prosecutions in May 1983. Mr Junkin signed the direction of 17 May 1983.

200 Mr Junkin explained that the Director and the Attorney General met regularly and discussed a wide range of matters, including high profile or sensitive cases, or of particular concern, including cases where the Attorney General as a Law Officer might be required to answer Parliamentary Questions. However, unless the consent of the Attorney General was specifically required by legislation, the general understanding of their working relationship was that decisions in, and professional responsibility for, the conduct of criminal proceedings in Northern Ireland were regarded as a matter for the Director. As we shall see, an instance where the Attorney General's consent was required arose in 1975 when the then Attorney General was asked for his consent in respect of a possible prosecution of Colin Wallace for offences under the Official Secrets Act, a matter to which we refer later in this chapter.

201 We are satisfied that there was nothing unusual or improper about the Director and Attorney General discussing the implications of the RUC requests to interview and question Ian Cameron. Anything to do with Kincora was likely to be a high profile matter, and the decision of the Director to request that the Caskey Phase Three report should be submitted to him in the form of a secret report was justified, given the sensitivity of the matters being examined in the Caskey Phase Three investigation.

202 The MI5 documents show that whilst the Director was understandably sceptical about the evidential value of the general line of questioning which the RUC wished to pursue with Ian Cameron, as early as 12 February 1982 he made it clear that his interest as Director was:

> "...to have the way clear for any prosecutions which ought to be brought. I therefore favoured police investigations continuing".[150]

150 KIN 100003.

203 Whilst the Director or his staff might advise the RUC on a potential line of enquiry if the RUC sought advice, as Bernard Sheldon recognised in his memorandum of 3 February 1982, Sir Barry Shaw was known for his:

> "Unwillingness to give directions to the investigating officers. We had inferred that this was connected with his well known desire to maintain the integrity of his office".[151]

204 It is noteworthy that on 1 October 1982 Bernard Sheldon recorded a conversation with the Attorney General's office in which he was told that the Director:

> "...had developed an argument that he needed to know whether Cameron had made a report to people in the Northern Ireland Office where there were some suspects. Their failure to take action in that event might be significant".[152]

205 However, this is not easily reconciled with the view expressed a short time later by the Attorney General's Legal Secretary to Bernard Sheldon that the Director "gave Nursaw to understand that he would not be concerned one way or the other whether they were answered".[153]

Was the DPP informed of Ian Cameron's answers to the 30 questions?

206 We have examined the original DPP file in which consideration was given to the Caskey Phase Three secret report, and we are satisfied that Sir Barry Shaw personally examined the papers, and then drafted the direction issued under Mr Junkin's signature on 17 May 1983. On 8 April 1983 Sir Barry Shaw agreed with the recommendations of Mr Junkin and Mr Junkin's superior Mr Cossham, both of whom were of the opinion that there was no basis for a prosecution on the Caskey Phase Three papers.[154] Sir Barry Shaw's request on 16 May 1983 to Mr Junkin to consider the draft direction satisfies us that Sir Barry Shaw drafted the direction himself after consideration of the file.

207 The direction is important and we therefore set it out in full.

> "Such information and evidence as is contained in this file does not warrant the initiation of criminal proceedings against any person.

151 KIN 105068.
152 KIN 105053.
153 KIN 105061.
154 KIN 100023.

> It is however, appropriate for me to refer expressly to two particular lines of enquiry which the investigating officer has sought to follow. Firstly, from the course of the interviews of Mr J C Wallace it seems that no information or evidence of materiality is likely to be made available to police by him. Either he has no such information or evidence or, if he has, he is unwilling to impart it. Further, I am not satisfied that he could be put forward as a credible witness upon any issue dependent on his testimony. Secondly, although Mr Cameron has not been and is not available to the police for interview, it does not appear that there is any admissible evidence which can be given by him relevant to any crime or crimes known to the police.
>
> In such circumstances and in the light of the whole of the careful and protracted investigations which Superintendent Caskey has conducted, it does not appear to be necessary or appropriate for me to request further investigation of whatever matters are or may be within the knowledge of either Wallace or Cameron. I have concluded that without their full and voluntary co-operation consideration of possible criminal proceedings cannot be advanced. Accordingly, but subject to consideration of any further facts or information which may otherwise come to light, I direct that this file may be marked no prosecution."[155]

208 So far as Ian Cameron is concerned, the relevant passage relates to his not being thought to be able to give any relevant admissible evidence relating to any crime or crimes known to the police. We consider that this was an inevitable, and legally impeccable, decision. Ian Cameron's answers to the 30 questions showed that, in the phrase attributed to the attorney general, the evidence of Ian Cameron was 'hearsay upon hearsay'. As the criminal law stood at that time there was no evidence that Ian Cameron could give that could be used in criminal proceedings. All he knew was what Brian Gemmell told him what Roy Garland had told him, and there was nothing to show that Roy Garland had personal knowledge of any criminal offences that had been committed by McGrath involving residents at Kincora, as opposed to Roy Garland's belief that McGrath was a person who might commit such offences. There was simply no legally admissible evidence to support a prosecution.

209 Did the Director have sight of the text of the replies of Ian Cameron to the 30 questions as recorded by Bernard Sheldon before he drafted this

155 KIN 100020.

direction? We have found no documentary evidence that directly shows that he did. Mr Junkin expressed his view at paragraph 7 of his witness statement where he said:

> "...I believe everyone, whether in the legal profession in Northern Ireland or otherwise, who knew him well would have regarded Sir Barry Shaw as a person who was very conscious of his responsibilities as a Public Prosecutor and who was meticulous and thorough in the conduct of his professional duties as the Director. Certainly that was my own experience of his approach to his work. If a document was available with the full answers I would be surprised if he accepted a gist of it or that he did not insist on seeing it in order to reach his decision in the case".[156]

210 A note made by the then Director Sir Alasdair Fraser QC (Sir Barry Shaw's successor) with Juliet Wheldon (then of the Attorney General's office) recorded that Miss Wheldon told him in 1990 that there had been a conference, presumably meaning a conference with the Attorney General, at which the Director was present. Sir Alasdair's note said that he would not be surprised if the conference took place between 6 April 1983 (when the Director agreed there was no evidence) and 17 May 1983 when the direction drafted by Sir Barry Shaw was issued. That suggests Miss Wheldon did not have a date for the meeting. Miss Wheldon and Sir Alastair Fraser are both dead. The absence of any contemporary document makes it difficult to be certain, but it seems to us that the most likely occasion on which the Director may have been shown Ian Cameron's answers to the 30 questions would be the meeting which it appears may well have taken place after 6 April and before 17 May 1983.

211 On balance we are satisfied that Sir Barry Shaw was shown the full text of the answers provided by Ian Cameron as recorded by Bernard Sheldon at some point prior to drafting the Direction that there should be no prosecution on 16 May 1983, and did not accept a mere gist or summary. As the RUC never received the answers, the text of the answers could only have come to Sir Barry Shaw either directly from MI5, or more likely was produced to him at his request so that he considered them before he reached his decision.

156 KIN 4504.

Holroyd and the DPP

212 There is material which indirectly throws some light on what Sir Barry Shaw's approach to this would have been. Mr Holroyd made allegations about allegedly unlawful actions by a number of military personnel engaged in operations in Northern Ireland. As a result, a large-scale RUC investigation led by D/Supt Caskey was launched. The prospect of this investigation involving the questioning of Army personnel, and the risk that this would damage the confidentiality of intelligence structures in Northern Ireland, caused considerable concern to the Government, and it is clear that these concerns were raised with Sir Barry Shaw.

213 On 3 February 1983 a meeting took place at which there was discussion about whether the RUC investigations into the allegations by Mr Wallace relating to Kincora, and the allegations made by Mr Holroyd about Army personnel, impinged on intelligence matters. Those present included Sir John Hermon, the Chief Constable of the RUC, Sir George Terry, the Chief Constable of Sussex, Mr Nurshaw, the Attorney General's Legal Secretary, the Director and Coordinator of Intelligence at the NIO (an MI5 Officer), Bernard Sheldon, (the Legal Advisor to MI5), as well as Sir Philip Woodfield, the Permanent Under Secretary of the NIO.

214 A note of the meeting made by Bernard Sheldon recorded that there was considerable discussion of the issues raised in both cases. During the discussion Mr Sheldon noted that Sir Philip Woodfield,

> "...reverted to the general problem of reconciling Police enquiries with the need to protect HMG's intelligence interests. He asked that in future any problems which might arise should be elevated to a more senior level. He thought this was preferable to, for example, CASKEY pursuing his enquiries by other means. We all agreed that this was an acceptable way to behave."[157]

215 It would appear that efforts were made after that meeting to agree a procedure along the lines suggested by Sir Philip Woodfield. On 4 March 1983 he wrote to the DPP following a meeting earlier that week with Sir Barry Shaw and outlined a procedure that could be adopted in such circumstances.

1 Any requests by the RUC would go to a named Colonel at HQNI indicating the intended line of questioning.

157 KIN 105493.

2 The request would be discussed at HQNI and then referred to Major General Garrett in London. He was the head of Army Security.

3 If General Garrett felt there was no objection then the RUC could go ahead with their questioning.

4 But if General Garrett concluded that the RUC's line of questioning would be likely to take them into the area of intelligence work he would discuss it with the RUC at an appropriate level.

5 If the RUC were not persuaded, the matter would then be referred to the DPP himself to decide the relevance of, and importance to, the information being sought to the police investigations.[158]

216 Sir Philip Woodfield commented that:

> "When we met and discussed this procedure in outline, you were kind enough to say that on the basis of the information I had given you, you saw no objections to the procedure in general and would be happy to play the part envisaged for you in particular. I should be grateful if, after you have reflected on the terms of this letter, on which I understand you may wish to consult the Attorney General, you would let me know if that remains your view. If it does, the next step will be for the GOC to put the new arrangements to the Chief Constable for his consideration, indicating that I have been consulted and am in agreement. I would also contemplate seeing the Chief Constable myself if that seemed helpful. Can you confirm that you are content that the Chief Constable should be told that you are aware of what is proposed and are prepared to play your part?"[159]

217 The matter was then discussed with the Attorney General on 22 March 1983, and again with the Attorney General and Sir Barry Shaw on 29 March 1983, according to a note for file prepared by Bernard Sheldon of MI5 on 30 March 1983.[160] Following these meetings the Legal Secretary to the Attorney General wrote to the Permanent Under Secretary of the NIO confirming the position of the Attorney General and the DPP in respect of the proposed procedure. He said that the Attorney General

> "…acknowledged that in the last analysis the decision must be taken by the Service or Security authorities and he said that, if the decision

158 KIN 190185-190187.
159 KIN 190186-190187.
160 KIN 105495-KIN 105498.

were that the information could not safely be made available, he and the Director of Public Prosecutions must accept this".[161]

The Legal Secretary confirmed that the Attorney General and Sir Barry Shaw had seen the letter in draft and were content with it.

218 The Inquiry has examined the DPP file on the Holroyd Case held by the PPS and found no document recording a response by Sir Barry Shaw to Sir Philip Woodfield's letter, or comment on the Legal Secretary's letter. However, given the approach to which he was said to have given his approval it appears to us probable that he would have acquainted himself with the responses by Ian Cameron to the 30 questions before he reached his decision on whether any prosecution should follow from the Caskey Phase Three Report. For him to do so would be in accordance with the approach mooted in the Holroyd Case. Whilst the two cases did not overlap, they presented similar issues as to how the police investigations were to be handled by the Army in the Holroyd Case and therefore offered a relevant precedent to be applied to the Caskey Phase Three investigation which was considered by the Director in April and May of that year.

161 KIN 105500.

PART SIX

James Miller and the *Sunday Times* in 1987

219 We now return to the letter written by James Miller on 7 April 1972 to which we have already referred. On 25 March 1987 the *Irish Times* carried an article saying that James Miller had been asked by MI5 to infiltrate Tara, to compile information on its leader William McGrath, and that Miller passed on this information to MI5 in 1970. The article said that Miller would not say if the information he compiled related to McGrath's homosexual or paedophiliac activities. This article appeared after a long article in the Sunday Times edition of 22 March 1987 referring to allegations made by Miller that MI5 had been active in promoting the UWC (Ulster Workers Council) strike. In a second article in the *Sunday Times* of 29 March it was said that:

> "...Miller claims that the Intelligence Services had known about the activities at Kincora for a number of years, and believes the boys' home was used to entrap men who would be blackmailed into providing information".[162]

220 A note to the Cabinet Office dated 30 March 1987 said that Miller had contacted officials the day before saying that he had not spoken to the author of the article since an earlier discussion. The note recorded that Miller confirmed that he had mentioned his acquaintanceship with McGrath to the author of the article, Barrie Penrose, whose second article Miller claimed was "built on machinations" and scraps of detail he (presumably Penrose) had not used in his original story.[163]

221 As a result Miller was interviewed by two officials on 6 April 1987, and their account of his explanation can be found at KIN 105072 to 105079. We note Miller's assertions that the statements attributed to him were a mixture of "pure fiction and gross distortion", and that he did not request money for his "revelations", nor was it offered to him. The reference at KIN 105075 to the follow-up article of 22 March appears to be a mistake for 29 March. Miller's position about what was attributed to him about Kincora is contained in the following passage from the report of his meeting with the two officials.

162 KIN 105071.
163 KIN 105080.

> "Kincora Boys' home (29 March Article). The reference to 'new claims' by [Miller] about the Kincora Boys' home was pure fabrication. The implication that [Miller] had made further revelations to PENROSE since the 22 March article was false. [Miller] had indeed been questioned by PENROSE about the Kincora Scandal but had told him honestly that he knew nothing about this episode except what he had read in the newspapers. His [officials] had never given him any reason to suppose that MI5 were interested in the place. He told PENROSE that he had fleeting contact with William McGrath in the latter's capacity as leader of the Tara Brigade. [Miller's] membership of Tara was short lived; he resigned from the organisation when it became clear that he was under suspicion as possible security forces infiltration agent. Though there had been speculation in Loyalist circles that McGrath was a homosexual, [Miller] did not know him well enough to comment on these allegations, and was unaware at the time of his 'housefather' role at Kincora.[164]

222 Of those involved in the preparation of the article, Miller has since died, as has Liam Clarke who was the other journalist mentioned in Miller's report. We approach Miller's account on the basis that the references attributed to him in the *Sunday Times* article of 29 March were accurately reported. As can be seen from the above quotation, the explanation Miller is recorded as providing to the officials of what he claimed he said to the journalist was significantly different from the terms of the article. He said that although there had been speculation in Loyalist circles that McGrath was a homosexual, Miller did not know McGrath well enough to comment on these allegations, and was unaware in 1971 and 1972 of McGrath's housefather role at Kincora.

223 We have examined all of the documents relating to James Miller held by MI5, and have found nothing to support the account he is said to have given to the *Sunday Times* other than the extract from his letter of 7 April 1972. In that letter he said that he had been told:

> "that the Tara OC McGrath had been accused of assaulting small boys and that he [McGrath] could not account for any cash that had been handed to him over a period of 12 months."[165]

164 KIN 105076.
165 KIN 4073.

Whatever the implication of the phrase that "McGrath had been accused of assaulting small boys", had Miller known of McGrath's employment at Kincora, or that Kincora was believed to be being used to entrap men we can see no reason why he would not have said so in 1972 in this brief reference just quoted. That he did not make any such reference in 1972, and that no other information has been found by us in the MI5 documents we have examined to support what the article claimed Miller said, led us to conclude that whatever he did or did not say to the *Sunday Times* reporters in 1987 did not represent what Miller actually knew in 1972.

224 When viewed in isolation the 1972 reference to the man known as McGrath who was the OC of Tara (and it will be remembered how difficult it was for the Security Services to establish who the man named McGrath was in 1971-73) having "been accused of assaulting small boys" could be said to imply either physical or sexual assaults of children. Given the notorious perpetration of physical violence by all terrorist groups in Northern Ireland, whether Loyalist or Republican, towards members of what they saw as "their" communities, it should not be assumed that the obvious meaning in April 1972 of "assaulting small boys" inevitably meant sexual assault.

225 By November 1973 MI5 had been told by the RUC that McGrath worked in Kincora, and their records show that McGrath was reported to be homosexual and to exploit other people's sexual deviations.[166] It is easy in retrospect to suggest that because McGrath was reported to be homosexual it should have been appreciated that he posed a risk that he would sexually abuse children, and therefore the reference to "assaulting small boys" should have been interpreted as indicating that he was sexually assaulting residents in Kincora.

226 However, we do not accept that that was an inevitable or correct deduction that should have been made at the time. We agree with Officer 9004 when he said to the Inquiry that "...the mere fact that someone who happened to be a homosexual in a boys' home" would not have met MI5's criteria for reporting such information to the police.[167] We cannot emphasise strongly enough that just because a man was homosexual did not mean then, any more than it does now, that he was

166 KIN 105008 and 105009.
167 Day 219, p 97.

capable of sexually abusing children. Child sexual abusers, although overwhelmingly male in our experience, can be either homosexual or heterosexual males, as shown by the number of married fathers who have sexually abused children, whether their own children or others.

227 We are satisfied that it was not until 1980 that MI5, the SIS, the MoD and RUC Special Branch became aware that McGrath had been sexually abusing residents of Kincora when that became a public allegation. All four agencies were aware that McGrath was alleged to be a homosexual, but had no proof of that. They were aware he worked in a boys' hostel where he was in a position of authority. They were aware of allegations that he had abused Roy Garland a long time before McGrath went to work in Kincora.

228 However, by November 1973 MI5, unlike the other three agencies, were also aware that the person who had by then been identified as William McGrath had been accused of "assaulting small boys". By virtue of section 5 (1) of the Criminal Law Act (Northern Ireland) 1967 MI5 were subject to the same legal obligation as everyone else in Northern Ireland to report the commission of an "arrestable offence" (that is an offence punishable with five years imprisonment) to the police where they knew or believed that such an offence, or some other arrestable offence had been committed. An alleged assault on small boys could, depending on the nature of the alleged assault, have been an arrestable offence which ought to have been reported to the police.

229 With the benefit of hindsight, and in the light of what is now known about McGrath's abuse of residents in Kincora, it might be argued it was the duty of MI5 to bring to the attention of RUC Special Branch that MI5 had received a report that McGrath had been accused of assaulting small boys, and that by not doing so the MI5 officers who had this information were in breach of that duty. However, we consider that to take that view would be unjustified for several reasons. First of all, although the information was known to MI5 because it had been received eighteen months before, eighteen months separated the receipt of that information and the information confirming the identity of William McGrath as the leader of TARA. Secondly, the information came to MI5 in a letter from James Miller who was simply reporting what an unidentified source said at a time when unsubstantiated allegations of discreditable behaviour by TARA members about each other were commonplace, and the report was therefore assessed as being of dubious reliability. Thirdly, the MI5

officers were concentrating on establishing what sort of organisation TARA was, and whether it could be a possible Loyalist terrorist group in the context of the extremely volatile political and security circumstances of that time. In all of those circumstances we do not criticise them for failing to appreciate the significance of this information.

230 We have earlier referred to the practice whereby intelligence services did not always share information with colleagues in other agencies, especially the RUC. The failure by MI5 to pass this information to RUC Special Branch may have been influenced by a desire to protect the existence of their source, and to ensure that his position was not compromised by any leak from the RUC, because it is clear that the other intelligence agencies were concerned that leaks to terrorist organisations, or hostile political figures, of a Loyalist and Unionist persuasion might occur.

231 We consider that had this information been passed to the RUC Special Branch and by it to their uniform colleagues, it may still not have made a significant difference to the approach of the RUC. It received much more detailed allegations from the Robophone message and from Valerie Shaw's conversation with D/Supt Graham, as well as Roy Garland's conversations with D/C Cullen that brought about the Cullen/Meharg investigations. An anonymous allegation of assault on small boys in an unspecified context passed to MI5 might not have added much, if anything, to that information. On the other hand, it might have prompted the RUC to look more closely at the information it held about McGrath and to investigate it more robustly.

232 There is nothing whatever in these references, or in the many files and documents that we have examined relating to the period from June 1971 to January 1976, to suggest in any way that McGrath was an MI5 agent, or was believed by MI5 to be an agent of any other British intelligence agency. It took from June 1971 until at least April 1973 to establish that the William McGrath who worked at Kincora and the William McGrath reported to the security agencies were one and the same. This strongly suggests that McGrath was not an agent.

PART SEVEN

The Secret Intelligence Service (SIS) and Kincora

233 We have already explained that the SIS was part of the Irish Joint Section and provided the first person to hold the post of Director and Coordinator of Intelligence (DCI). We have already referred to the exchanges of information between the Security Service and the SIS in 1976 and 1977 when the SIS obtained a copy of the 3 Brigade Intelligence Report on Tara dated 28 January 1976, and it is unnecessary to repeat the details of those exchanges. We have also examined the documents handed over by Brian Gemmell to two SIS officers on 15 October 1976[168] when Brian Gemmell was apparently under the impression that he was speaking to MI5 officers. However, the request of 31 January 1977 by an SIS officer in London to MI5 merits further examination. This was a request to MI5 and intelligence staff in Northern Ireland to consider whether the source mentioned in the 3 Brigade letter "could be retasked for further information".[169] The response of intelligence staff in Northern Ireland to the suggestion that Tara could be "a worthwhile target", and that they supported recruitment to penetrate Tara, was revealing.

> "Beyond knowing that there is a recruiting campaign in Tara, we know little about it, so are not sure whether we are yet in a position to discover a loophole that could be exploited by IJS. We do not know, for instance, where Tara seeks its recruits, apart from other organisations" [Intelligence Staff NI] certainly considers Tara to be a worthwhile target. Both [blank] and [blank] have been briefed to find traces of this elusive organisation".[170]

234 It has been alleged that McGrath had been an SIS agent for many years, perhaps from as long ago as 1958, for example by Chris Moore at pages 29 and 30 in his book, "*The Kincora Scandal*". If that were the case, it is remarkable that in 1977 the SIS where saying that they knew very little about Tara, and describing it as an "elusive organisation". If McGrath had been an SIS agent for many years, then SIS was in a position to find out whatever it needed to know about the Tara Brigade whenever it wished, if its leader was in fact one of their agents. That the SIS knew very little about Tara in 1977 strongly suggests that McGrath was not an SIS agent either then or at any other time.

168 Day 218, p 26.
169 KIN 3510.
170 KIN 3512.

The SIS and homosexuality

235 In his witness statement of 27 May 2016, Officer A explained the approach of the SIS to a question of homosexuality in the following way.

> "SIS does not exploit children or vulnerable adults for operational purposes, nor tolerate their abuse either by their staff, or those who work on their behalf or in their support including SIS agents. In dealing with cases of child abuse or exploitation, our guiding principle is, as is set out in the UN Convention of the Rights of the Child and in the Children Act, that the best interest of the child should always prevail."[171]

236 However, that is a statement of the SIS approach at the present day. Was that the position at the time the Inquiry has to consider?

237 In his evidence on Day 218, Officer A explained that while homosexuality was of interest to the SIS, SIS would not use homosexuality to pressurise an individual, but because homosexuality would make others vulnerable to blackmail it would be of interest to SIS. He expressed that in this way.

> "Our concern.. Our concern would have been.. The concern around that would have been that people who were practising homosexuals at the time, at a time when it was possibly illegal in some parts, or certainly not as socially acceptable in other areas, might come under pressure from hostile foreign intelligence services or others seeking to undermine our National Security."[172]
>
> "I mean, I would say SIS at that time and... would not use blackmail in that way, but our concern would have been over other... others using blackmail on people who were homosexual. So that's why we would have had concern for that vulnerability."[173]

238 We have examined all the material held by the SIS on McGrath and Tara that has been disclosed to us, as well as other documents held by the SIS which we asked to see and which were provided to us. We found nothing whatever that suggests that McGrath was ever an agent of the SIS, or that the SIS had any knowledge of McGrath or Tara other than the information and documents to which we have referred. Nor have we

171 KIN 3525.
172 Day 218, p. 25.
173 Day 218, p. 26.

found any evidence to suggest that the SIS knew anything more than MI5 knew before the revelations in the *Irish Independent* of 24 January 1980 made public the sexual abuse of residents in Kincora by McGrath and others.

239 For the same reasons that we have explained in respect of MI5's knowledge of McGrath's homosexuality, information which came from the RUC, MI5 or the Army, we are satisfied that the Secret Intelligence Service cannot be legitimately criticised for its failure to appreciate that McGrath was in fact abusing residents in Kincora because we are satisfied it had no other information which suggested that he had abused, or might abuse, residents in his care at Kincora other than that he was homosexual.

Sir George Terry's report

240 On several occasions we have referred to the investigation carried out by Sir George Terry, the Chief Constable of Sussex, and his officers, at the invitation of the Chief Constable of the RUC. Sir George Terry's Terms of Reference were summarised by the Secretary of State for Northern Ireland to the House of Commons on 18 February 1982 as being:

> "To investigate allegations about the way in which the Police have conducted their enquiries and in addition to have general oversight of the continuing investigations."[174]

This meant that Sir George Terry's remit was firstly to examine the manner in which the RUC conducted the Caskey Phase One investigation, and secondly to oversee both the Caskey Phase Two and Phase Three investigations, because Caskey Phase Three was the secret part of the Caskey Phase Two.

241 Sir George Terry and his team carried out an exhaustive re-examination of the Caskey Phase One investigations, as can be seen from the extremely detailed reports and associated witness statements and exhibits prepared and compiled by D/Supt Harrison and D/Supt Flenley. In doing so, the Sussex Police interviewed all those former residents of Kincora who had been interviewed by the RUC, as well as many other witnesses, and we have previously referred to parts of the Sussex Police reports and to some of the witness statements taken by the Sussex

174 KIN 40003.

Police. In his report which was published on 28 October 1983,[175] Sir George Terry did not confine himself to his Terms of Reference, but expressed his views on a number of matters. These included the shortcomings as he saw them of the Social Services relating to Kincora, and steps that he considered should be taken to remedy those shortcomings. Those matters were not within his Terms of Reference. They had been examined in considerable detail by the Hughes Inquiry, and we have examined them in our Report, so it is unnecessary to make any comment on his views on those matters.

242 A matter which was within his Terms of Reference related to the approach of the RUC to the events in 1974 and 1976, which we have examined in considerable detail in the previous chapter. He said at No 51 (b):

> "There was no cover-up or concealment of evidence or disciplinary breechs by the RUC personnel. There was some degree of lack of awareness over information / intelligence but this was at a time of intense terrorist activity which placed an excessive strain on Police resources and undoubtedly dictated priorities. There was, therefore, at this time an understandable inability [sic] to recognise that extremely vague information which arose in 1974, if probed thoroughly, may well have revealed that which was finally discovered in your 1980 investigations. In 1976 there was some other information which was not thoroughly recognised as relating to that which came to hand in 1974. In no way, however, by any stretch of imagination was this a question of a cover-up, only, I repeat, a lack of awareness, of interpretation and recognition. Any later critics had the benefit of what never exists at the time, namely, hindsight. In fact, it was D/Superintendent Caskey's excellent work which ultimately focused attention upon this!".[176]

243 In the previous chapter we have expressed our views on the manner in which the RUC investigated the Robophone message in 1973; the way in which D/Supt Graham dealt with the information he was given in 1974; and, the Cullen/Meharg investigations of 1974 and 1976. It will be apparent that our views do not coincide with Sir George Terry's assessment of the competence displayed by the RUC in relation to those matters.

175 KIN 102162.
176 KIN 40019 and 40020.

244 At 51 (k) he expressed the following conclusion.

> "The media have also given a degree of prominence to the fact that some Military Circles were aware of homosexual mis-practice in the Kincora Boys' Hostel. The Military sources had been very frank with me and perfectly open during the ongoing enquiry by your own team under D/Superintendent Caskey. Let me say quite clearly that once more I sought evidence from all sources including the media with negative result."[177]

245 Sir George Terry's assertion that military sources were "very frank" and "perfectly open during the ongoing enquiry by your own team under D/Superintendent Caskey" is difficult to understand. Whilst Ian Cameron was an officer of the Security Service, it is clear that his role at Army HQNI was such that he should have been regarded by Sir George Terry as coming within his description of "Military sources". Whatever Sir George Terry may have been told about Ian Cameron, and what Ian Cameron did or did not say or do, appears to have come only from MI5 through Bernard Sheldon. As we have seen, Sir George Terry was aware of MI5's efforts to prevent the RUC from interviewing Ian Cameron about the allegations made by Brian Gemmell.

246 We regard Sir George Terry's assertion that military sources had been frank with him and perfectly open with D/Supt Caskey as unjustified.

The reasons for setting up the Hughes Inquiry

247 In an earlier chapter we recalled that on 18 February 1982 the Secretary of State for Northern Ireland announced that he did not intend to reconstitute the McGonagle Inquiry, but intended to appoint another Inquiry after the current police investigations were complete (that is Caskey Phase Two and Phase Three and the Terry Inquiry).

> "...with a High Court Judge as Chairman sitting in public. The Terms of Reference of such an Inquiry and the powers it might need cannot be determined until the results of the present investigations are known. But I am anxious that there should be no lasting cause for public disquiet that the truth has not been wholly discovered."[178]

177 KIN 40023 and 40024.
178 KIN 21274.

248 Following the statement by the Secretary of State, the following exchange took place between him and Mr Gerry Fitt MP. Mr Fitt asked whether the Inquiry:

> "Would enable Mr Colin Wallace, a former British Army Security Spokesman, who gave an interview to journalists in 1975 and made them aware of all the aspects of Kincora, to be brought before the Inquiry or the Courts?"[179]

249 The Secretary of State replied by saying:

> "The hon gentlemen asked about the powers of the Tribunals of Inquiry (Evidence) Act [1921]. He asked whether, if we decided on that type of Inquiry, the Inquiry would have power to call for people who had been imprisoned for one offence or another. Such an Inquiry has complete powers to call for evidence from whomsoever it desires. Therefore, the answer to his question is 'Yes'."[180]

250 The statement by the Secretary of State, and the exchanges between himself and Mr Fitt MP, were significant for a number of reasons. While there was a call for an Inquiry to be set up under The Tribunals of Inquiry (Evidence) Act, 1921 (The 1921 Act) the Secretary of State did not definitely commit himself to establishing an Inquiry under that Act. However, he had committed the Government to there being an Inquiry which would be chaired by a High Court Judge, which would sit in public and call witnesses. Significantly the reference to Colin Wallace, at that time serving a prison sentence for manslaughter, being brought before such an Inquiry identified one of the reasons that contributed to the ultimate decision that there would not be a public inquiry held under the 1921 Act.

251 It was not until the DPP issued his direction of no prosecution on 18 May 1983 following consideration of the Caskey Phase Three Report, and the publications of Sir George Terry's conclusions on 28 October 1983, that the way was clear for a decision to be taken on the form the promised inquiry should take and its Terms of Reference. Pending the delivery of the Terry Report, since 1982 the Northern Ireland Office had been giving considerable thought to whether the proposed Inquiry should be held under the 1921 Act or, as was eventually the case, a more limited form of Inquiry should be held under the provisions of Article 54 and Schedule 8 of the Health and Personal Social Services (Northern Ireland) Order, 1972 (The 1972 Order).

179 KIN 21275.
180 KIN 21275.

252 The NIO considered a 1921 Act Inquiry would have had a number of disadvantages. Lord Salmon's 1966 Royal Commission on Tribunals of Inquiry had suggested that the use of the 1921 Act should be "limited to matters of public importance concerning which there is something of a nationwide crisis of confidence". Officials doubted whether a local concern in Northern Ireland could be said to come within the category of a nationwide crisis of confidence. In any event, a debate in Parliament would be required to set up such an Inquiry.

253 A further factor was that it was anticipated that a 1921 Act Inquiry would be very long and very costly. It was later estimated that it might cost as much as £2 million.[181]

254 Another consideration was that a general immunity from prosecution for witnesses would normally be considered necessary, although some form of immunity would still be required for any Inquiry, whether under the 1921 Act or the 1972 Order.

255 A particular consideration appears to have been the concern that public hearings would attract public attention, and perhaps provide a platform for "those anxious to make political mileage or satisfy personal grudges."[182] A 1972 Order inquiry was thought to be speedier and less likely to become a media circus.[183]

256 An important technical point was that although a 1921 Act Inquiry would have power to subpoena witnesses throughout the entirety of the United Kingdom, as the Secretary of State had expressly recognised in his reference to Colin Wallace in the exchanges in the House of Commons already quoted, a 1972 Order inquiry could only subpoena witnesses in Northern Ireland, something which was to prove significant when the Hughes Inquiry tried to interview Colin Wallace.

257 Notwithstanding the disadvantages of a 1921 Act inquiry, a meeting of Northern Ireland Office officials chaired by the Permanent Under Secretary on 30 March 1982 decided that:

> "public expectations had been aroused; and the wider powers of subpoena of the [1921] Act gave it an advantage over the 1972 Order. It was agreed that, in the absence of powerful arguments to the contrary, a 1921 Act would be required."[184]

181 KIN 102159.
182 KIN 102156.
183 KIN 102156.
184 KIN 102157.

258 Early in 1983, as the expected date of publication of the Terry report approached, discussions within the Northern Ireland Office on the form of inquiry resumed in earnest. At this stage it was still considered that only a 1921 Act inquiry was appropriate. As a meeting of officials on 28 April 1983 presciently concluded:

> "It was likely that the extent of concern in the Province would mean that only the institution of such a wide ranging and powerful Inquiry [under the 1921 Act] would represent a sufficient response by Government".[185]

259 We have not considered it necessary to recite the details of every meeting or discussion of the arguments for or against a 1921 Act inquiry because, as a helpful Northern Ireland Office survey of events prepared in 1990 observed, "the picture began to shift" by 30 June 1983 when further considerations were examined. One was that the Security Service was concerned about the likely intrusion of the proposed inquiry into intelligence matters if the Terms of Reference were as wide as the NIO had in mind. The reference to there being at least two witnesses who it was thought could come forward with evidence which might, perhaps gratuitously, reveal information about the structure and range of activities of the Intelligence Services at the time in question was significant. One of the two possible witnesses was Colin Wallace, who was explicitly referred to in advice given to the Secretary of State on 20 July 1983 as a person serving a prison sentence for a manslaughter charge. The other, who was referred to as "a born again Christian who served in Military Intelligence" was obviously Brian Gemmell.[186]

260 A further concern was that the Chief Constable of the RUC was expressing the view very strongly against any public inquiry with Terms of Reference that would allow "all the rumours to be aired yet again".[187]

261 Advice tendered to the Secretary of State on 20 July 1983 examined three possibilities.

1 A 1921 Act Inquiry

2 A 1972 Order Inquiry.

3 A non-statutory Inquiry without formal powers.

185 KIN 102158.
186 KIN 102159.
187 KIN 102158.

The Secretary of State considered the advice and discussed it with Sir Philip Woodfield, the Permanent Under-Secretary of the NIO. The Secretary of State was apparently attracted to the suggestion of a 1972 Order Inquiry chaired by a Northern Ireland High Court Judge, expressing the hope that:

> "Whilst much would depend on public reaction to the publication of the Terry Report, it would be possible to resist establishing an Inquiry under the 1921 Act".[188]

262 In the event, what emerged was a 1972 Order Inquiry. The Lord Chief Justice of Northern Ireland had been consulted about making a Northern Ireland High Court Judge available as Chairman, but his lack of enthusiasm for that suggestion was evident. The Secretary of State announced the setting-up of the Hughes Inquiry on 18 January 1984. It had the following Terms of Reference:

> "to
>
> a. inquire into the administration of children's homes and young person's hostels whose residents were subjected to homosexual offences which led to convictions by the Courts or where homosexual misconduct led to disciplinary action against members of the staff, and into the extent to which those responsible for the provision of residential care for children and young person's could have prevented the commission of such acts or detected their occurrence at an earlier stage;
>
> b. consider the implications for present procedures and practices within the system of residential care, including in particular the adequacy and effectiveness of arrangements for the supervision and protection of children and young persons in residential care; and
>
> c. make recommendations with a view to promoting the welfare of such children and young persons and preventing any future malpractice."[189]

263 The Hughes Inquiry Terms of Reference therefore excluded any examination of the Security Services. In the event, the Hughes Inquiry only examined in a restricted fashion the RUC's action in the 1970s insofar as it considered the Cullen/Meharg investigations of 1974 and

188 KIN 102159.
189 KIN 75380.

1976. That was in the context of what was or was not disclosed to social services at the time, and did not examine the wider issues of the adequacy of the RUC response because that was clearly outside the Terms of Reference of the Hughes Inquiry.

264 The NIO officials recognised in 1982 that despite the strength of the arguments against holding a 1921 Act Inquiry, a 1972 Order inquiry was not likely to allay public concern about Kincora. We are satisfied that the balance of the argument tipped away from a 1921 inquiry in favour of a 1972 Order inquiry because of the concerns expressed in 1983 by the Security Services about the risks to intelligence operations if witnesses such as Colin Wallace or Brian Gemmell had a public platform on which to advance their arguments. A further factor was the objections of the Chief Constable to a public inquiry which would permit, "all the rumours to be aired again". The Chief Constable's view is entirely understandable given the decisive views expressed in the Caskey Phase One, Two and Three Reports. Together these rejected allegations of abuse of residents by public figures and others, and dismissed the allegation of a cover-up. These conclusions were reached after an extremely extensive and thorough investigation. The Chief Constable no doubt anticipated that a public inquiry which was empowered to look at allegations relating to the Security Services would inevitably involve going over the same ground as had been covered by the RUC investigations to date. This was particularly as the outcome of the Sussex Police investigations under Sir George Terry supported the RUC findings.

265 Whilst there were valid and strong arguments against a 1921 Act inquiry as opposed to a 1972 Order inquiry, it was always possible that a 1972 Order inquiry would not allay the public concerns for the reasons identified by Northern Ireland Office officials on 28 April 1983.

266 The concerns about revelations of intelligence methods in Northern Ireland cannot be dismissed as merely an excuse for avoiding the examination of matters which might result in inconvenient truths being established. MI5 had repeatedly asserted that it had nothing to hide in respect of a criminal investigation, but the security and political environment was still extremely complex. Terrorist murders, bombings and shootings were still occurring at a very high level of frequency, and to that point all initiatives to bring about a political solution in Northern Ireland had foundered. Although we recognise the weight of the arguments against a wide-ranging public inquiry under the 1921 Act

at the time, as anticipated in April 1983 it proved in practice that the 1972 Order option did not bring an end to the rumours and innuendo about what did or did not happen in Kincora so far as the police and intelligence agencies were concerned.

267 We are surprised that greater consideration was not given to a variation of the third option, namely a non-statutory inquiry without formal powers. The direction of the DPP that there should be no prosecution merely established that there were no grounds for criminal proceedings. Without a prosecution the full nature and extent of the extremely thorough Caskey Phase Two and Three Investigations and the equally thorough Sussex Police investigations would never be made public. Only Sir George Terry's conclusions were published. Therefore, so far as the public, politicians and the media were concerned they were being asked to take on trust that the role of the Security Services had been examined.

268 However, as we have concluded in our consideration of Sir George Terry's Report, it appears to be the case that he accepted the assurances of MI5 without investigating the Ian Cameron issue, and officials in the NIO were aware at the highest level that the RUC had been obstructed in their efforts to interview Ian Cameron.

269 We are satisfied that the NIO were not justified in forming their belief that the RUC investigations, the decision of the DPP, and Sir George Terry's Report, taken together, provided a firm basis upon which to argue against an inquiry into the role of the Security Services. We recognise the validity of the concerns of the Security Services if intelligence methods were to be examined in public at a time of continuing serious terrorist activity and political instability. Nevertheless, we consider that it should have been possible to establish a non-statutory inquiry conducted by a senior judge or retired judge from outside Northern Ireland which would sit in private, but have access to all the relevant witnesses and documents. There was a recent precedent for an Inquiry of that general type in the form of the *Report of the Committee of Inquiry into Police Interrogations Procedures in Northern Ireland*[190] under the chairmanship of His Honour Judge H G Bennett QC, which reported in 1979. That committee sat in private but heard oral evidence on fourteen days at Stormont and on three days in London, as well as hearing from 58 witnesses.[191]

190 Cmnd. 7497 *Report of the Committee of Inquiry into Police Interrogations Procedures in Northern Ireland.*
191 Ibid, pp.3 and 4.

270 An Inquiry of that type presided over by a senior judge from outside Northern Ireland, such as either a serving or a retired lord of appeal or a lord justice of appeal, would have provided a mechanism whereby an authoritative and thorough investigation could be carried out of those issues which were not possible because of the Terms of Reference of the Hughes Inquiry. Such an Inquiry could have been provided with suitable Terms of Reference which would have enabled it to proceed in private in parallel with, or to be held immediately following, the Hughes Inquiry. Whilst it would be held in private, the Report could have provided sufficient detail to explain why it reached its conclusions without imperilling intelligence operations. We have seen nothing to suggest that such an option was seriously considered, let alone explored in detail.

271 Whilst it could be argued that such an inquiry should have been set up is to view the matter with the advantage of hindsight, we do not accept that that is the case because in July 1982 NIO Officials accurately foresaw the very problem which was not answered by the deliberately narrow terms of the Hughes Inquiry, namely that such a limited inquiry would not provide answers to many of the questions which were being raised at the time. The decision that was made to rely on the basis of the DPP's direction of no prosecution and the outcome of the Terry Report was misguided.

PART EIGHT

Military intelligence, Tara and McGrath

272 When considering Brian Gemmell and Ian Cameron, we have examined whether there was a MISR as Brian Gemmell claimed to the police when interviewed by D/Supt Caskey on 16 July 1982. For the reasons we have already given, we concluded that Brian Gemmell mistakenly conflated the short 1975 MISR and the 14 October 1976 document that he prepared and then handed to two members of the SIS on 15 October 1976. We now turn to consider other material that is relevant to establishing what military intelligence knew about McGrath. By military intelligence we mean the Intelligence Units of the Regular Army and Intelligence or information obtained by Intelligence Officers in the UDR.

273 As Junior Counsel to the Inquiry explained on Day 220, the Ministry of Defence have not been able to find two files which it is clear were still in existence in 1990, because they were referred to in the supplementary Rucker Report prepared in 1990. This was an internal Ministry of Defence Report to which we refer later. The two files were the HQNI Tara file and the 39 Brigade Tara file, which appear to have been passed to the Security Service at some point in 1990. Officer 9004's evidence on behalf of the Security Service was that the two files were in the possession of the Security Services as late as 18 June 1990, but it was not possible to say with any certainty what happened to them after that. He speculated that they might have been returned to the Ministry of Defence, or destroyed for one reason or another.[192]

274 We have already considered the evidence of Major Saunders, who examined the HQNI Tara file and the 39 Infantry Brigade file and as a result produced eleven documents which he gave to D/Supt Caskey. Some of these came from the HQNI file, 5523/6, others from a file 3350/16, which was recovered from 39 Infantry Brigade. The documents from 39 Infantry Brigade included the 22 May 1975 MISR. Although neither the HQNI Tara file nor the 39 Infantry Brigade file can now be found, their contents were examined at various dates between 1982 and 1990 by Major Saunders, by Mr Noakes who was an MoD researcher, and by Mr Rucker. We have the eleven documents produced from both files by Major Saunders and which he provided to the RUC. This makes it possible to establish with reasonable confidence that nothing else of relevance to this Inquiry was in the two files, although we cannot say that with complete certainty as the files cannot now be found.

192 Day 219, p.45.

Witness C

275 On Day 222 we heard evidence from witness C who was a Major serving in the Intelligence Branch at HQNI at Thiepval, known as G Int in 1974 and 1975. He explained that he was a desk officer responsible for looking at terrorist or extremist protestant groups. As such it was his task to receive reports from field officers, and then to make assessments about the reports before disseminating that information as he considered appropriate.[193] One of those groups was Tara.

276 Witness C wrote a report on Tara dated 6 July 1974 in which he said that Tara's existence had been known since 1972, and that little had been heard of it until the appearance of posters in Belfast on 11 April 1973. He went on to say that:

> "…very little is known about TARA which has always been shrouded in mystery. (It claims to be a secret organisation). Some personalities known are:-
>
> a William McGrath, 5 Greenwood Avenue, Upper Newtownards Road, Belfast, CO of Tara, has communist leanings and a reputed homosexual".[194]

277 This assessment is interesting for a number of reasons. First of all, the address given for McGrath of 5 Greenwood Avenue was wrong, and in any event out of date. When he lived at Greenwood Avenue it was at number 4 and not at number 5 and he had been living at 188 Upper Newtownards Road for a considerable period of time. Secondly, although the report refers to McGrath as a "reputed homosexual", it makes no reference to his employment at Kincora, or to Kincora in any form. Thirdly, witness C's view of Tara was revealing when he commented to us that at the time his branch did not regard Tara as a secret organisation, saying "to us they were just an organisation".[195] In his inquiry witness statement he said that Tara was an organisation of limited interest to the Army.[196] He also told us that the reference to McGrath's homosexuality was a piece of information that would not have been of great importance to him in his work.[197]

193 Day 222, p.44.
194 KIN 2513.
195 Day 222, p.49.
196 KIN 2506.
197 Day 222, p49.

278 Witness C explained that he had asked Colin Wallace for a copy of a sheet he knew Wallace had on Tara, and he believed that he based his report of 6 July 1974 on the document Colin Wallace gave him.[198] That document contains the following reference to McGrath.

> "Other information that has come to light includes the name of the OC-William McGrath. He is said to be a homosexual and has conned many people into membership by threatening them with revealing homosexual activities which he had initiated. He is also thought to owe more allegiance to the Red Flag than to either the Union Jack or the Tricolour".[199]

279 If witness C is correct that he obtained this document from Colin Wallace, then it must have been created by Colin Wallace at some time before witness C drew on it to prepare his 4 July 1974 report on Tara. We consider it significant that the document Colin Wallace prepared makes no reference to Kincora, or to McGrath's employment there, or to McGrath being believed to sexually assault residents at Kincora. We are satisfied from the passage quoted above that the reference to McGrath having conned many people into membership relates to membership of Tara. We refer to this document again when we examine Colin Wallace's account of events.

280 The next Army document in chronological sequence that refers to McGrath was written by witness C on 26 February 1975, and was addressed to RO 2. We are satisfied that RO 2 was a subordinate of Ian Cameron. Given the importance of this document we set it out in full.

> "William McGrath (Tara) – 188 Upper Newtownards Rd
>
> 1. Subject first came to notice in April 1973 when Jean Coulter said he was leading Tara and that his son was also involved. Enquiries with PR HQNI indicated that McGrath was homosexual and had communist tendencies. Clifford Smyth (Tara and DUP) was reported to be living at McGrath's house at that time.
> 2. By Oct 73, further reports confirmed that McGrath was homosexual and was using the Puritan Printing Co for propaganda purposes. During October and November 73, police reports indicated that McGrath received a visitor from England, a Miss De Verne, and 2 Dutch journalists, one of them called Elisabeth

198 Day 222, p.51.
199 KIN 2515.

Schaait. We do not know the purpose of these visits but on 6 Nov 73 an A2 report stated that McGrath intended to visit KIN 390 of Amsterdam.

3. McGrath again came to light in September 1974 when a Tara/ULA propaganda cassette tape was transcribed which exhorted the listener to send funds to McGrath, giving his previous address, 5 Greenwood Avenue, Belfast.
4. An intelligent though devious man, who needs extremely careful 'handling'. I do not at present fully trust him but he is undoubtedly a mine of useful information on past incidents, organisation and personalities."[200]

281 This assessment of McGrath incorporated some new information. It correctly gave his address as 188 Upper Newtownards Road. Whilst the reference to "PR HQNI" suggests that this was referring to the document received from Colin Wallace in July 1974, because it echoes the assertion in that document that McGrath was homosexual and had communist tendencies, the reference in paragraph 3 to McGrath coming to attention again in September 1974 is a reference to events which must have occurred after witness C wrote his July 1974 report.

282 It is paragraph 4 that is of particular significance to the Inquiry. On reading paragraph 4 one possible construction of that paragraph is that witness C had formed his assessment of McGrath because he had met him, and that McGrath was providing information to the Army. However, we consider that, looked at in isolation, the other construction is that it was an assessment arrived at by the author after considering other information available to him. Witness C explained to us that what he did was to prepare an overall assessment based on the information that his desk, that is the Protestant/loyalist extremist desk, had on McGrath at the time. He was emphatic that he never met McGrath, nor that he intended to do so at the time. As he put it, "that's a pure paper assessment".[201]

283 There is no other material which we have so far examined which provided any basis for a suggestion that McGrath was an Army agent. The way in which he was referred to in the contemporary records shows that he was a person who was of only limited interest, and that interest was

200 KIN 2518.
201 Day 222, p.58.

because he was the commanding officer of Tara. It is also clear that relatively little was known about him. These considerations suggest to us that the explanation witness C gave for the way he wrote paragraph 4 was entirely plausible, and having seen and heard him give evidence we accept that his evidence on what he wrote and why he wrote it, and what he meant, was credible and reliable.

284 The next Army document in chronological terms that we examined in this context was dated 22 March 1975. This came from a Sergeant and a Corporal attached to an Army Intelligence Unit based at Castlereagh in East Belfast which reported to 39 Infantry Brigade. They reported that since 1974 they had been working on Tara, and had been given information by an RUC constable attached to what they described as the SPG (Special Patrol Group) "Int", that is intelligence. The Special Patrol Group was an RUC uniformed unit that performed various policing tasks as necessary whenever and wherever it was needed, such as quelling riots or carrying out large scale police searches. The SPG was a predecessor of the present day PSNI Mobile Support Units which perform broadly similar functions.

285 The 22 March 1975 Report contained a great deal of background information on McGrath, and on his relations with other figures including Roy Garland. The Report said that much of the information was attributed to Miss Shaw, and that "Miss Shaw has a grievance to settle with McGrath, whom she dislikes intently for moral reasons".[202] While the report refers to McGrath as the "warden of Kincora Boys Hostel", and states that there were letters "written by McGrath to one Roy Garland when they were having an affair", it contains no reference to McGrath abusing residents in Kincora.

286 As we have already considered the events involving Brian Gemmell and Ian Cameron that occurred in the months following this report of 22 March 1975 we now turn to examine the document dated 28 January 1976. It will be remembered that this is the document which had made its way unofficially to MI5 in October 1976, when a copy was handed over by Brian Gemmell on 15 October 1976. The 28 January 1976 document came from 3 Infantry Brigade in Lurgan and was signed by Major Halford McLeod. The document was sent to both GI "Int" HQNI and GI "Int" HQ39 Infantry Brigade: it consisted of four pages and two pages of press cuttings which

202 KIN 105013.

were attached. The report explained that the information came from three sources. It contained considerable detail about, and observations upon, McGrath, his religious and political views and his associates.

287 The following three passages are relevant.

a) Paragraph 6 "McGrath is a homosexual and makes a practice of seducing promising young men".[203]

b) Paragraph 7 "McGrath is currently described from the 1975 Belfast Street Directory as a Welfare Officer. He is thought to be running some form of boys' home".[204]

c) Paragraph 17 heading conclusion

> "The picture is confused. You [HQNI and HQ39 Infantry Brigade] are in a better position to assess the information than we are. Perhaps the most interesting aspect is the [sic] many contradictions around the central figure, McGrath".[205]

288 The reference to McGrath "seducing promising young men" clearly refers to adults involved at some stage with Tara, as can be seen from the names of those whom McGrath was said to have seduced. The reference to his being "thought to be running some form of boys' home" is clearly incidental to McGrath's financial and work history. The boys' home was apparently unknown, and there is no reference to Kincora, or to McGrath sexually abusing residents.

289 When interviewed by D/Supt Caskey in September 1982 Major Halford McLeod said he was not aware in which boys' home McGrath was employed. He continued:

> "I cannot recall any specific boys' home being mentioned. When I was preparing this report I was not so much interested in McGrath's homosexual activity but rather in his involvement with Tara and possible Communist links and links with Ian Paisley and his links with security forces."[206]

290 Major Halford McLeod said that he had received the information upon which this report was based from UDR Major H who was a UDR officer, and from a source to whom he was introduced by UDR Major H, but

203 KIN 30298.
204 KIN 30298.
205 KIN 30299.
206 KIN 30151.

he could not remember who the source was. At this time 3 UDR to whom UDR Major H was attached was under the command of 3 Infantry Brigade.[207] UDR Major H told the police in 1982 that Major Halford McLeod did not meet three people whom Major Halford McLeod had named through him, one of whom was Roy Garland. He said in his 1982 police statement that at the time he was the 3 UDR Intelligence Officer and that he collected information on McGrath. He said:

> "I cannot remember exactly what all Garland told me but I do remember Garland saying that McGrath was a homosexual and was employed in a boys' home. He did not tell me what home McGrath was employed in or that McGrath had committed any offences."[208]

291 UDR Captain N also served in 3 UDR. He explained what he told UDR Major H in a statement he made to D/Supt Caskey on 28 September 1982 in this way:

> "The information I passed was that I believe McGrath to be a homosexual and his association with up and coming young men in Unionist Politics, including his involvement with TARA. I knew Roy Garland and it was me who introduced Garland to [UDR Major H]. It was Garland who referred to the fact that he believed that McGrath was working in a boys' home. The name of the home, was to the best of my knowledge, not stated."[209]

292 When the accounts given by Major Halford McLeod, UDR Major H and UDR Captain N are compared with the contents of Major Halford McLeod's January 1976 report they indicate that whilst a number of Army and UDR officers believed McGrath to be homosexual, or that he was reputed to be, and that McGrath was alleged to have seduced "promising young men", the young men were adults connected with McGrath through Tara. Although it was established that McGrath worked in a boys' home, Kincora was not mentioned by name, nor was any allegation made that he was abusing the residents of any boys' home, whatever he was said to have done in the past so far as Roy Garland was concerned. All these officers, including WITNESS C, were interested in McGrath solely because he was the Commanding Officer of Tara. That McGrath worked in a boys' home was merely incidental to their interest in him and that interest was because of his connection with Tara.

207 KIN 30151.
208 KIN 30152.
209 KIN 30154.

PART NINE

The allegations of Colin Wallace

293 Mr Colin Wallace is a former civilian employee of the Ministry of Defence who was employed as a Senior Information Officer at HQNI when he was moved to a post in Lancashire in January 1975 and then dismissed later that year. Mr Wallace has made many statements over the years to the effect that the Army were aware that residents of Kincora were being sexually abused by McGrath and did not intervene to stop it. In particular, he claims to have prepared a long memorandum dated 8 November 1974 which recommended that the Army, amongst other steps, make a final attempt to get the RUC to investigate the matter. This memorandum appears in Who Framed Colin Wallace? by Paul Foot, first published in 1989. The references which we make to that book are taken from the paperback edition published in 1990. *Who Framed Colin Wallace?* considered this memorandum as well as other matters relating to Colin Wallace, including the circumstances leading to his conviction for the manslaughter of Jonathan Lewis in 1980.

294 From its investigations the Inquiry was aware that over the years Mr Wallace had written many letters to prime ministers, ministers, civil servants, members of parliament, as well as speaking to many journalists, about his allegations relating to Kincora. The Inquiry examined letters from him in the possession of various Government departments and these, and the allegations contained therein, led us to decide that he should be invited to help the Inquiry with its investigations into Kincora because of what he had said and written in the past. The Inquiry therefore contacted Mr Wallace through his solicitors by letter dated 19 April 2016. We invited him to become a core participant in the Kincora module, and made it clear that if he was prepared to become a core participant, depending upon his financial circumstances, he may be eligible for legal representation at the Inquiry at the Inquiry's expense. In addition, we requested that in any event he provide the Inquiry with a witness statement dealing with 32 questions which the Inquiry regarded as relevant to the issues it identified.

295 Mr Wallace's response by way of an email of 26 April 2016 from his solicitor was to request details of witnesses and documents in order to assist him to decide whether "he wishes to engage with the Inquiry in any capacity". The Inquiry responded to Mr Wallace's solicitors on

28 April 2016 pointing out that it was not the Inquiry's practice to disclose details of this nature before the opening of the module, and it saw no reason to depart from that practice. The Inquiry repeated the invitation to Mr Wallace to become a core participant, and again pointed out that he may be eligible for funding for legal assistance to enable him to prepare the witness statement the Inquiry had already requested him to provide. This letter from the Inquiry solicitor concludes:

> "If Mr Wallace does not wish to assist the Inquiry in its work by providing a witness statement in which he answers the questions set out in my letter of 19 April, questions which are plainly relevant to the Inquiry's work, the Inquiry will have no alternative but to conclude that Mr Wallace refuses to answer any questions and will proceed accordingly."[210]

296 Mr Wallace's solicitors replied by email on 29 April 2016 saying that he "will not engage in any capacity with the Inquiry".

297 Despite Mr Wallace's attitude, on 31 May 2016 on the opening day of the Inquiry's public hearings into Kincora the Chairman stated that although Mr Wallace, Brian Gemmell and Roy Garland had each refused to become core participants, and had not provided witness statements dealing with the various questions posed to them by the Inquiry, if they changed their minds by Friday 10 June 2016 and provided the witness statements requested, they could still take part in the hearings as core participants. If they did not do so by 10 June it would be too late. Mr Wallace did not respond to that invitation, and the public hearings into Kincora ended on 8 July 2016.

298 Two months after the public hearings ended, Mr Wallace wrote to the Inquiry on 9 September 2016 attaching a 51-page document headed "Response to the Historical Institutional Abuse Inquiry by Colin Wallace September 2016". He attached a large number of documents to that letter. From the document and the attachments it was clear that Mr Wallace had closely analysed the transcripts of the public hearings during the intervening period of two months.

299 He subsequently sent four further letters.

1. On 26 September 2016 he sent a further two-page letter to the Inquiry, to which he attached two further documents.

210 KIN 123332.

2. On 17 October he sent a nine-page letter to the Inquiry attaching seven further documents.
3. On 27 October 2016 he sent a three-page letter to the Inquiry attaching three further documents.
4. On 7 November 2016 he sent a two-page letter to the Inquiry attaching four further documents.

The Inquiry has considered each of these letters and documents, and we took them all into account. In due course these will be placed on the Inquiry's website.

300 As will become apparent, Mr Wallace has engaged in voluminous correspondence about Kincora over the years. We do not intend in this Report to refer to each and every letter he has written, or to every document or press cutting to which he has referred, nor to every document referred to by the Inquiry in the Kincora module transcripts which may touch on Mr Wallace. The Inquiry has examined and considered them all. For the Inquiry to respond to each and every one of those documents, many of which contain repetitions of the same or similar points made in other documents, or refer to matters that are not relevant to Kincora would be out of all proportion to their relevance to the issues which the Inquiry has considered.

301 When assessing the credibility of the various accounts Mr Wallace has given about his knowledge of Kincora we have taken into account that he has not provided a witness statement to this Inquiry dealing with the questions posed to him, and that in the past he has refused to answer pertinent questions about Kincora which had been put to him by the RUC and by the Hughes Inquiry. In his response to the Inquiry Warning Letter Mr Wallace complained that he had been given insufficient time to respond to, and comment upon, the extracts of the Draft Report sent to him which referred to him and in which he was criticised. However, he produced a 45 page response with some attachments in which he again avoided responding to relevant matters within his knowledge to which the Inquiry referred in the draft sent to him, but concentrated on points and material which were of little value to the Inquiry. We have taken into account his continued failure to provide relevant information.

302 Mr Wallace's history is unusual in many respects, as will be apparent from the following brief résumé of some of the principal events in which he was concerned. Some of these events, particularly his conviction

for the manslaughter of Jonathan Lewis, are only indirectly relevant to the issues which this Inquiry considered it necessary to examine, but because they are closely interwoven with those issues some reference to them is inevitable when his allegations about Kincora are being examined.

303 In 1975 Mr Wallace was dismissed from his post as a Senior Information Officer by the Ministry of Defence after he attempted to pass classified Ministry of Defence documents to a journalist. As we shall explain, the documents were found and handed to the RUC before the journalist could receive them. Mr Wallace appealed his dismissal to the Civil Service Appeals Board (CSAB), which ultimately suggested that he be permitted to resign. He and the Ministry of Defence accepted this with the result that Mr Wallace resigned from his employment with effect from 31 December 1975.

304 At the time, Mr Wallace contended that the nature of his work was such that he was acting properly in attempting to pass the documents to the journalist, and that this would be apparent from an examination of his job description. The full job description was not produced, although some reference was made to its scope by Mr Wallace's representatives in their submissions to the CSAB. The failure to produce a full description, and what Mr Wallace maintained was therefore a distortion of his true position, was a major grievance on his part at that time, and remains so.

305 Unknown to him at the time, but as has since been established, the MoD approached the Chairman of the CSAB before the hearing and secretly briefed him about the reasons relating to Mr Wallace's dismissal. When this emerged in 1989, the then Conservative Government appointed David Calcutt QC to review the matter. Mr Calcutt concluded that representatives of the MoD had been in private communication with the Chairman before the appeal, and that the full range of Mr Wallace's work was not made plain to the CSAB. He concluded that Mr Wallace should not have been dismissed and recommended that he receive £30,000 compensation.

306 Mr Wallace has long contended that prior to his dismissal he was involved with a project known as "Clockwork Orange". For many years the Government denied that there was such a project, but in 1989 documents which led to the revelation about the approach to the CSAB

also confirmed that, in the Government's view, whilst there had been a discussion of such a project it never came to fruition. The denials that Clockwork Orange existed continue to annoy Mr Wallace to the present day, as can be seen from correspondence to which we later refer. It was the discovery of documents relating to Clockwork Orange that set in train the events that led to the appointment of David Calcutt QC to review the hearing before the CSAB.

307 Mr Wallace has also claimed that his dismissal in 1975 was because of what he knew about Kincora. On 17 February 2004, when giving evidence to a committee of Dáil Éireann (the lower house of the Irish Parliament) in connection with a report prepared by Mr Justice Barron on the Dublin and Monaghan bombings, Mr Wallace said:

> "I was forced out of Northern Ireland as a result of a dispute with the security service over the Kincora Boys' Home scandal in Belfast..."[211]

308 As we shall see, Mr Wallace was posted from Thiepval to a new posting in Preston in Lancashire early in 1975. If, as he claims, that posting came about because of a dispute with the Security Service over what was happening in Kincora that would be an important matter supporting his general credibility. For that reason we have examined the circumstances surrounding his leaving Northern Ireland and which led to his dismissal from his post as a Senior Information Officer, and the events surrounding the appeal before the Civil Service Appeal Board.

309 Following his resignation from his MoD employment at the end of 1975, Mr Wallace took up employment with a local authority in the South of England. In 1980 he was charged with the murder, and convicted of the manslaughter of Jonathan Lewis and sentenced to ten years imprisonment. His initial appeal against his conviction was dismissed. Subsequently, his conviction was referred back to the Court of Appeal (Criminal Division) which quashed the conviction and decided not to order a retrial. Much of the correspondence to which we refer in which Mr Wallace engaged while he was in prison serving the sentence on the manslaughter charge related to his conviction on that charge. Those circumstances are not relevant to the issues considered by the Inquiry which relate to Kincora.

211 KIN 122004.

310 The 8 November 1974 document to which we have already referred is of great significance. If it was compiled in November 1974, as it purports to have been, it very strongly supports the credibility of Mr Wallace's account of what he knew and what he claims others in HQNI knew about sexual abuse in Kincora in 1974. The document first came to the notice of the RUC when it was passed to Sussex Police by Mr Holroyd in 1984. In due course we examine issues which have been raised about its authenticity, but we consider it appropriate to examine those issues, and the nature and content of the document, when we come to consider other material relating to events in 1974 and 1975. We examined the relevant events relating to Mr Wallace and Kincora in a broadly chronological form, but before turning to them we consider it appropriate at this stage to refer to his background and work at Thiepval.

Colin Wallace's background

311 Although different dates are given in the documents we have examined it appears that Mr Wallace was born on 6 June 1943, and is now 73. He was educated at Ballymena Academy in County Antrim, leaving in 1960 after passing eight O-levels. He then appears to have attended Belfast Technical College before working for a number of years in a pharmaceutical company in Ballymena. In 1964 he joined the Territorial Army Volunteer Reserve (TAVR) and was commissioned as a Captain in the Army Cadet Force (ACF). He also served in the Ulster Special Constabulary (USC, commonly known as the 'B' Specials) from 28 December 1965 until 1968.[212] On 17 January 1972 he became a part-time member of the UDR,[213] and in May 1972 was granted a commission as a Second Lieutenant, with the acting rank of Captain backdated to 18 January 1972. During his service with the ACF he undertook a number of courses. It is clear from the details of the courses he went on between 1966 and 1971, which included parachute courses at the French Free Fall School at Pau, the US Parachute School at Fort Benning in Georgia, and the New Zealand SAS (Special Air Service) Patrol Course, that he was a very active part-time soldier, and in particular became an enthusiastic free fall parachutist.[214]

212 KIN 30007.
213 KIN 30361.
214 KIN 30363.

312 On 1 May 1968 he became a civilian employee of the Army Information Service based at Lisburn as an Assistant Information Officer, and by the end of 1974 had recently been promoted to Senior Information Officer. We consider his role in the Army Information Service when we examine the events of 1974 and 1975 which culminated in his dismissal and appeal to the CSAB, but at this stage we examine the circumstances in which he has claimed that he first heard of concerns about the abuse of boys who were resident in Kincora.

Contact by a social worker in 1972

313 In 1982 Mr Wallace described the circumstances in which he first became aware of what he described as "the situation at Kincora" in the following passage of a longer document he prepared at that time:

> "I believe it was in early 1972 that I was first made aware of the situation at Kincora. I had just returned to HQ Northern Ireland from Londonderry where I had been on detached duty for the 'Bloody Sunday' tribunal. At this time I had been running an Army Free Fall Parachute Team (The Phantoms) as an Information Policy/Community Relations Project. The team had been a very popular attraction and appeared at numerous events and functions, including many where the Security Forces would otherwise have been very unwelcome. Shortly after one such display I was telephoned by a woman who claimed to be a social worker and who said that she had been given my name by a clergyman at whose church fete the Parachute team had recently given a display. She said she had some information to give me in confidence and I agreed to meet her in Belfast. When I met her she told me that she had a young boy in her charge who was a resident in the Kincora Boys' Home and who claimed that he had been sexually assaulted by the staff of the Home. She went on to say that there had been similar claims by other inmates of the Home and that although the matter had been reported to the RUC no action had been taken. She asked if, through Army channels, I could get the police to take action. Quite clearly she was very distressed and she asked me to ensure that her identity was not disclosed."[215]

314 There are a number of aspects of this account that are curious. First of all, it is difficult to understand why Mr Wallace's name would have been

215 KIN 102801 and 102802.

given to this lady by a clergyman. If she were concerned about her charge we would have expected her to be pointed elsewhere and not to an Army Information Officer. There is no suggestion in this account that this lady had approached more obvious candidates, such as an MP or journalist, if the RUC were not taking action. Secondly, this conversation is said to have taken place sometime after the Widgery Hearings ended. Those hearings ended in Northern Ireland on 14 March 1972, and the first resident of Kincora known to have been sexually assaulted by McGrath was HIA 532 who arrived at Kincora on 9 April 1972. He gave evidence to us on Day 208, and said that Mains and Semple never abused him but McGrath abused him on each of his three periods in Kincora, the first of which started on 9 April 1972. He told us that he never reported the abuse to anybody, and that his social worker was a male.[216] HIA 532 could not therefore be the person about whom the female social worker was speaking. If such a conversation took place, it must have related to abuse of other residents by either Semple or Mains before 1972. As is now known, Mains had been the subject of complaints in 1971, which were not reported to the police, nor were the earlier 1967 complaints about him reported to the police. There were no complaints known about Semple until the Caskey Phase One RUC investigation in 1980. It is therefore difficult to understand who this lady could have referred to, or how a reference came to be made by her in 1972 to a report to the police and the RUC not taking action when no report had been made to the Police in any shape until 1973.

315 The identity of the female social worker to whom Mr Wallace referred was clearly something which is important to any examination of his account, and there had been a number of attempts to obtain further information about this lady to see whether she could be traced in order to establish whether Mr Wallace's account could be confirmed. On 21 April 1985 Mr Wallace wrote to his solicitor responding to an enquiry by the Hughes Inquiry as to whether he would be prepared to assist it. The Inquiry had asked whether Mr Wallace had any preconditions, and he said that there were three, the third being

> "…an acceptance of the fact that I would not be prepared to disclose the name of any of my sources or members of the Intelligence Services."[217]

216 Day 208, p.134.
217 KIN 35387.

316 The most surprising aspect of this account is that Mr Wallace said that the lady told him that the boy "had been assaulted by the staff of the Home". (Emphasis added) Whilst McGrath joined the staff at Kincora in 1971, he is not referred to by name in this account, although by 1982 when Mr Wallace wrote the account McGrath's name had been at the centre of references to Kincora in the media following his conviction and sentence at the end of December 1981. However, when *Who Framed Colin Wallace?* appeared in 1989 Mr Wallace claimed the lady told him that it was McGrath who was abusing the boy and no reference was made to other staff, that is to Mains and Semple, abusing residents, and Kincora was not referred to at all.

> "She said that she had been in charge of a youngster who had alleged that he had been assaulted by William McGrath. She said the matter had been referred to the police, but the police didn't seem to be doing anything about it."[218]

Given the attention to the smallest detail that is a characteristic of Mr Wallace's communications the change between 1982 when it is "the staff" who are responsible for the abuse described by the lady, to McGrath being the abuser is striking. We regarded this as a significant inconsistency between accounts Mr Wallace has given of this conversation.

317 On Friday 13 December 1985 Mr Mercier, the solicitor to the Hughes Inquiry, went to Lewes Prison to see Mr Wallace. Two of the questions he wished to put to Mr Wallace on behalf of the Inquiry were the name of the social worker and the name of the boy assaulted. Mr Mercier's note of that meeting stated that Mr Wallace's response, after consulting his solicitor, was to say that there was no point in answering questions in the narrow context suggested by the Hughes Inquiry. His answers could be taken out of context and used to create a story which was not true.[219] Mr Wallace's letter to his solicitor the next day accepted by implication that he was not prepared to answer these questions.[220]

318 Our Inquiry also wished to establish if at all possible the identity of this person and Mr Wallace was asked to answer the following questions:

1 Give the identity of the woman who is described at p134 of *Who Framed Colin Wallace?* as approaching him in 1972 to voice concerns about Kincora.

218 Page 134 of the book, KIN 5200.
219 KIN 75521.
220 KIN 104104.

2 If he does not know her name, please give any information, such as her age, hair colouring, size or any other feature that might help to identify her.

3 Did she say the address or department in which she worked?

4 Did he make any record then or subsequently of the conversation? If so, if he still has such a record please produce the original to the Inquiry."[221]

None of these questions have been answered.

319 Mr Wallace's 1982 account strongly implies the social worker did identify herself to him at the time in some way, because he says she asked him to protect her identity. We can conceive of no valid reason why Mr Wallace has not been prepared to provide the name, or any information that would assist in identifying this social worker. By his account of her actions she was performing a public duty. She would not have been subject to the Official Secrets Act. Mr Wallace's consistent refusals to identify the social worker, and the strange, even bizarre, account as to how and why the social worker approached him, raised considerable reservations in our minds as to the credibility of his account. His refusal to provide any information that could help to identify her without any good reason suggests that this social worker may not even have existed.

Colin Wallace, the press and "psyops"

320 Mr Wallace's role as a Senior Information Officer was an unusual one. Between July 1973 and September 1974 Peter Broderick was the head of the Army Information Service unit at HQNI, and as such Mr Wallace's superior until Mr Broderick left Northern Ireland in September 1974 for a new appointment elsewhere in the Civil Service. In a lengthy statement which he submitted to the CSAB in 1975 in support of Mr Wallace, he described how there were two distinct sections or branches within the AIS at HQNI. One was PR (Public Relations) which dealt with what we regard as conventional public relations work on behalf of the Army by issuing press releases, liaising with journalists and matters of that sort. The other section was a separate military unit with the title IP (Information Policy). Mr Broderick explained that the brief of IP was:

221 KIN 123326.

> "…to use psychological means to assist operations strategically and tactically. It is a skill that requires sensitivity, political finesse, and a thorough knowledge of the situation".[222]

321 While Mr Wallace worked closely with IP, Mr Wallace's primary job, according to Mr Broderick, was working with the press. Mr Broderick described that task in another passage from his statement to the CSAB.

> "Though on the staff of public relations, he was used by Information Policy as their outlet to the press. He also had knowledge of the Irish situation which was totally unique in the Headquarters and surpassed that even of most of the Intelligence Branch. As time progressed, he was not only the main briefer of the press, but also the advisor on Irish matters to the whole Headquarters and – because of his personal talents – contributed much creative thought to the Information Policy Unit. In order to do his job he had constant and free access to information of high classification and extreme sensitivity."

322 "Wallace's primary job was to win friends among the press and to gain their total confidence as a reliable source of information. By agreement with Intelligence in each case, he was supplied with selected information about terrorists, their activities, their sources of money and arms at home and overseas, of the allegiances of so-called innocents and such matters. This – together with his long-term and intimate knowledge of the Irish scene – made him an invaluable contact for the press. Almost all of his background briefings he gave non-attributably – and it is a measure of his skill and the regard for him by the press – that I cannot recall a single occasion when any reporter, even from the hostile papers, disclosed the source of the briefings."[223]

323 Although a part-time officer in the ACF, and later in the UDR, Wallace was not a Military Officer at HQNI, but a civilian employee. Nevertheless it is clear that he worked very closely with the Military IP section, and no doubt his part-time military role helped him to understand, and so to work closely with, and be of use to, the military staff in Information Policy.

222 KIN 102118.
223 KIN 102119.

324 It is clear that Mr Wallace was highly regarded by his military colleagues, and by Mr Broderick, as can be seen from another passage in his CSAB statement.

> "I do not hesitate to say that Colin Wallace is the best thing that ever happened to Army Public Relations in Northern Ireland; that if it had not been for his talents, knowledge and efforts, the Army could well have lost the propaganda war; and I could not wish to meet anyone more dedicated to the Army than he was and, so obviously, still is."[224]

325 In 1975, in a document which we refer to as the "Damage Assessment", Ian Cameron, the then ASP at HQNI, recognised Mr Wallace's value to AIS and HQNI.

> "Wallace's experience, knowledge and advice was invaluable to the AIS in maintaining good relations with the Press, and in projecting the Army's interests through the Media."[225]

In the Damage Assessment Ian Cameron drew a distinction between Information Policy and Information Planning, referring to the latter as IP, but it was unnecessary for us to dwell on these distinctions.[226]

326 The reference by Mr Broderick to the role of Information Policy requires some elaboration. Mr Wallace has claimed on many occasions over the years that his work involved activities designed to deceive the media and others in order to damage the public perception of individuals or organisations perceived to be hostile to the Army and to the state.

327 Some of the activities he has described are commonly referred to under various titles, such as "Black Propaganda". As the following description by Ian Cameron in the Damage Assessment indicates, propaganda can be divided into different categories depending on the identification of its source of origin.

> "a. Black Propaganda. Any propaganda, the origin of which is completely concealed from the target audience;
>
> b. Grey Propaganda. Any propaganda, the origin of which is left in doubt. This category also covers propaganda the origin of which may be initially concealed but which may subsequently become known to the target audience.

224 KIN 102120.
225 KIN 190196.
226 KIN 190192.

c. White Propaganda. Any propaganda the origin of which is readily apparent."[227]

328 That may take many forms, such as a press briefing to plant a story in a newspaper or in radio or TV programme, or the creation of forged documents designed to provide direct or indirect support for the apparent truthfulness of the false information. the…'It is not for this Inquiry to decide whether or not such practices as were undertaken by elements of the Army in Northern Ireland in the early 1970s, particularly the creation of false documents, that is forgery, were legitimate tactics or weapons used in Northern Ireland in the early 1970s. That such practices did exist and were part of the stock in trade of Mr Wallace and others will be clear from documents we examine later in the chapter.

329 Over many years much ink has been spilt over what exactly Mr Wallace did or did not do, and what he was allowed to do. In a letter to the Prime Minister of 21 July 1990 Mr Wallace described his activities in this way:

"The MoD has been totally dishonest through this whole affair in that the department knowingly employed me for a number of years to disseminate disinformation including forged documents and faked classified information to the press, but now not only deny that most of these activities ever took place but also refuse to investigate any corroborating evidence which I submit to them. It is probably true to say that most of my disinformation work from 1971 to 1975 was in direct conflict with Civil Service Codes of Conduct, however, I was not only commended and promoted for my work, I was also recommended on three occasions for the MBE for my performance of such duties."[228]

330 Recommendations for honours are not revealed and so the Inquiry has proceeded on the basis that Mr Wallace was recommended on three occasions for the award of an MBE.

331 That Mr Wallace did engage in black information and propaganda was ultimately recognised by the Ministry of Defence in 1989. We refer later to the circumstances in which documents which led to that recognition came to light. In the present context relating to the nature of the work Mr Wallace did, it is sufficient to refer to the following description of his work contained in a note attached to the letter sent by the Secretary of State for Defence to the Prime Minister on 25 September 1989.[229]

227 KIN 190193.
228 KIN 104251.
229 KIN 104026.

332 In the note the work Mr Wallace did was described as follows.

> "(1) Wallace dealt frequently with issues which were classified within HQNI at least up to the time at which details were provided unattributably to the media. It is possible – but cannot now be confirmed – that extracts from (or copies of) documents so classified may have been handed unattributably to members of the press; Wallace should only have engaged in the later actions when authorised to do so by his superiors but available evidence suggests that they may have given him considerable latitude to use his own judgement.
>
> (2) Wallace was directly or indirectly involved in a number of projects which involved spreading misinformation: documents recently recovered from Archive suggest that on occasions the information disseminated was false."[230]

333 Mr Wallace's "job description" was described in this way.

> "c. Wallace's formal job description referred only to normal PR and public information duties; the MoD gave this document to the CSAB. But whilst at HQNI Wallace also became involved in supplementary work relating to black propaganda and misinformation. At one stage the Chief Information Officer sought approval for the issue of a supplementary document which identified and would have regularised Wallace's involvement in the latter activities. No record has been found to confirm that the supplementary job description was approved and issued. But Wallace has indicated a clear knowledge of what the draft document covered and he sought to have it presented in evidence to the CSAB. No such document was given to the CSAB but Wallace's Union Representative, who had been briefed in confidence by the MoD about the broad nature of Wallace's supplementary duties, drew the CSAB's attention to them, as did the Chief Information Officer in his evidence to the CSAB."[231]

The Chief Information Officer was Mr Broderick.

Mr Wallace and the need for clearance of proposals

334 For the MoD a central issue was that Mr Wallace had acted without authorisation as can be seen from the letter from the Secretary of State to the Prime Minister in the passage just quoted above where he said,

230 KIN 104027 and 104028.
231 KIN 104027 and 104028.

> "...Wallace should only have engaged in the latter actions when authorised by his superiors".

In his Damage Assessment prepared in 1975 Ian Cameron described the procedures for obtaining clearance for specific IP Projects.

> "21. The planning and production of specific I.P. Projects is more closely controlled than the exploitation of themes in the course of unattributable briefings. Unless they are of no more than trifling importance they are discussed formally in a committee meeting presided over by the GSO I IP and attended by the GSC III IP and the SIO; the latter being present to advise on production and dissemination. [The SIO would have been Mr Wallace] When a draft outline plan has been agreed and approved by the CIO clearance is sought from the appropriate authority; the initiation of major schemes or those which could have serious repercussions have to be referred to the CLF; those with a political content have to be cleared in consultation with the NIO. The GSO I IP has discretion to carry out low level projects provided their aims are within the scope of already laid down policy.
>
> 22. Execution is undertaken only when the appropriate clearances have been obtained. Dissemination of printed material is normally facilitated through units on the ground or through the post."[232]

335 From the Army perspective there were therefore five relevant points.

1. The project had to be formally discussed and approved by the CIO, and until September 1974 that was Mr Broderick. At the meeting to discuss it the SIO, at that time Mr Wallace, would have been present in order to advise on production and dissemination.
2. Clearance had then to be sought from the appropriate authority.
3. This meant that projects with serious repercussions had to be referred to the Commander Land Forces. At that time the CLF was Major General Peter Leng.
4. Those with a political content had to be cleared in consultation with the NIO.
5. Execution of the project would only be undertaken after the appropriate clearances had been obtained.

336 That Mr Wallace had "considerable latitude" as to how he acted was acknowledged in a note prepared in July 1975 in advance of a meeting

232 KIN 190195.

between Sir Michael Cary, the Permanent Under Secretary of the MoD, and Bill McCall of the Institution of Professional Civil Servants, the Union representing Mr Wallace at the forthcoming CSAB hearing. The relevant part for present purposes was:

> "To judge by what Wallace has told us, his case will hinge on the extent of his discretion. And there is no doubt that Wallace was permitted a wide degree of discretion. But one thing, as you will no doubt now know, Wallace was a key man in the Army's "information policy" or black propaganda activities in Northern Ireland, and secondly he had an encyclopaedic knowledge of the Irish scene."[233]

337 As we shall see in due course, the nature of Mr Wallace's work was central to the events which led to his dismissal. These events, and his dismissal, are only relevant to this Inquiry in so far as they relate to the assertions Mr Wallace has made that he was forced out of Northern Ireland because of what he knew about Kincora, and to whether the contemporary documents support the claims he has made about his knowledge, and the actions of the Army, in relation to Kincora between 1972 and 1975.

Colin Wallace and the Bill Fuller episode

338 An example of the way in which such IP activity was conducted is the way in which material was placed in the media which would show an American named Bill Fuller in an unflattering light because of his perceived support for the IRA. This episode is enlightening for a number of reasons. It illustrates how such material was created, and Mr Wallace's part in disseminating it. It is also relevant because it is apparent that although SIS were involved, SIS went to considerable lengths to conceal their involvement from Mr Wallace.

339 In the 1970s a major concern for all Government departments and agencies directly involved with Northern Ireland, such as the NIO, MoD and the security agencies, was the level of public sympathy and financial support for terrorist organisations in Northern Ireland from individuals and organisations in the USA. One of those individuals was Bill Fuller, described by SIS in a 21 March 1975 summary of Wallace's RUC interview of 12 March 1975 as "an American millionaire who

233 KIN 102090.

provides bail and funds for the IRA".[234] Throughout 1974 SIS provided information about Mr Fuller to Mr Wallace to enable Mr Wallace to pass that information on to a sympathetic journalist. The information was not passed directly to Mr Wallace by SIS, but through G Int at HQNI.

340 The use of G Int as a conduit was to provide a "cut out" to avoid Mr Wallace suspecting where the information he was being given came from.[235] The intention was that when the journalist discussed the story with Mr Wallace he would then refer queries back to G Int, and G Int would then obtain information which would be given to Mr Wallace to give to the journalist. G Int obtained the information from SIS and/or the Army as required. The information was given to Mr Wallace who, it was believed by SIS, would understand that the information had been compiled by G Int, that is by the Army, and not by the security agencies.[236]

341 SIS maintained that in this instance false information was not provided, but true facts were passed on in this fashion.

> "We can therefore be confident that SIS had no conscious operational involvement with WALLACE of any kind. It appears that we used WALLACE only once, on an unconscious basis, than using G Int as a cut-out. This was in the FULLER case, a straight information operation. Our role was to provide true facts through G Int for PR HQNI to pass on without attribution to suitable journalists..."[237]

The reference to using Mr Wallace "on an unconscious basis" implies that he would not realise that the facts emanated from SIS.

342 In this instance it appears that the procedure adopted was that MoD Officer J showed what was described as a "sanitised write-up" to Mr Wallace who then intended to add further details which he had obtained from his "press sources" and could then add to the information by giving it orally to the journalist concerned.[238]

343 A telegram to SIS in London from the IJS at HQNI asked for further information which was being requested by the newspaper concerned. This suggests that in this particular instance SIS were simply providing information in response to requests by a journalist to Mr Wallace, but

234 KIN 3585.
235 KIN 3598.
236 KIN 3578.
237 KIN 3602.
238 KIN 3578 and 3579.

doing so in a way in which they intended would conceal from Mr Wallace that they were involved. However, in 1990, after a detailed search of their records, SIS recognised that Mr Wallace may have realised what the true source of the operation was.

> "It is unclear whether WALLACE was aware that SIS was one of the original providers of this information. Strictly speaking WALLACE should not have known, and the files indicate the care that was taken by [IJS HQNI] to ensure that he did not find out. However, WALLACE must have known that the detailed information he was given could not have come from Army sources alone. We are therefore dependent to a considerable extent on the Army's own security in this case, and must hope that knowing winks and glances were not exchanged. Otherwise WALLACE could claim that he was part of an SIS/MI5 dirty tricks operation, and provide sufficient details to be believed."[239]

344 Whether or not Mr Wallace did know, or suspect, that the facts about Bill Fuller came from SIS, he played his part in preparing the information for dissemination to the journalist concerned. An SIS memo of 7/8 April 1975 contains the following reference to Mr Wallace's efforts in this respect.

> "The sanitised write-up on Bill FULLER (copy attached). In handing this to [redacted], WALLACE photocopied on to the last page some of his own information, ie that contained in para 3 of our tel [SIS LONDON] of 7 June 74."[240]

345 The reference to Mr Wallace photocopying his own material onto the last page suggests that he may have put together the document he later passed to the journalist by using a photocopier to join two documents together, that which he received from G Int and some of his own information. That could of course have been a perfectly innocent means of compiling a document which would still clearly reveal that it had at least two distinct origins. The alternative is that that could be a device to conceal that the document had two distinct origins by making it appear that it was a single document. Whichever was the position, at best it is a possible example of the skills Mr Wallace clearly possessed in view of his own admission that he regularly created false documents.

239 KIN 3599.
240 KIN 3587.

PART TEN

Mr Wallace's knowledge of sexual abuse in Kincora in 1973 and 1974

346 In 1982 Mr Wallace prepared a long document entitled "Political and Security Implications regarding the disclosure of Security Classified Information to assist in the investigation of the allegations relating to the Kincora Boys' Hostel, Belfast." For convenience we refer to this as "Political and Security Implications", and it is to be found in full from KIN 102798 onwards. In it Mr Wallace described what he did after meeting the social worker to whom we have already referred, and who, he said, reported abuse at Kincora to him.

> "I reported my conversation with the social worker to a member of the Intelligence staff when I returned to Lisburn and asked if he could raise the matter with the RUC through our liaison channels. Some days later the officer with whom I had raised the matter came to my office and asked me to leave the incident alone because it was already under consideration by other people. I did not regard this as unusual at the time because it frequently happened when two agencies became involved in the same activity or with the same target. I had no further information about Kincora for almost a year and I do not know if my information was ever passed to the RUC. However, in 1973 a Senior Officer at HQNI gave me a written brief relating to McGrath and his activities and asked if I could get a reporter to investigate the matter. I did pass the information on to several journalists but I do not think any of the information was ever published."[241]

347 From this passage it is apparent that Mr Wallace was saying that he reported his conversation with the social worker to a member of the intelligence staff shortly after the conversation took place. That would indicate that the discussion was around the early spring of 1972. The account clearly indicates that the member of the intelligence staff concerned took the matter away and then returned and told him that it was being dealt with. The identity of the officer concerned is clearly of the utmost importance in establishing whether or not any such information was ever passed to him by Mr Wallace, and if so what the nature of the

241 KIN 102802.

information was. If there was such a conversation or conversations in the terms suggested by Mr Wallace that would also be of the utmost importance when considering the credibility of his account. The Inquiry asked Mr Wallace to answer the following questions:

5 Please identify the "Intelligence Officers" or "Intelligence Officer" who said to him that this is already being dealt with; See p.135 of *Who Framed Colin Wallace?*.

6 When and where did that person or persons say this?"

348 Mr Wallace has not answered these questions. If he is concerned about revealing the identity of a member of the Intelligence Services, and that identity consequently being disclosed to the public, he could have asked the Inquiry to treat the name in confidence. From his close study of the transcripts of Module 15 he must be well aware that the Inquiry gave designations to several present and retired witnesses from MI5, MI6 and the Army in order to protect their identities. We can see no reason whatever why Mr Wallace has not answered these questions.

349 In the extract above from the 1982 document Mr Wallace claims that he did pass what the social worker told him to a number of journalists. In *Who Framed Colin Wallace?* at page 136 the following journalists are named as being provided with a "briefing paper" by Mr Wallace.[242] We will have occasion to consider the document or documents to which such a description may apply in due course, but each of the four journalists named below was interviewed as part of the RUC Caskey Phase Three investigation in 1982. A fifth journalist, Conor O'Cleary, was interviewed in 1985 because he had been out of the jurisdiction in 1982 during Caskey Phase Three.

350 Each of these journalists recalled they were told various details about Mr McGrath, and that he was homosexual, but none recalled Kincora being mentioned to them at any time. The journalists, and the papers to which they were attached at the time, were as follows:

1 David Blundy (*Sunday Times*) said Kincora was never mentioned at any Army briefing, nor homosexuality at any home in Northern Ireland, nor had he any knowledge of homosexuality in any children's home in Northern Ireland in 1973 or 1974.[243]

242 KIN 5201.
243 KIN 30075.

2 David McKittrick (*Irish Times*) said Mr Wallace did not tell him that McGrath worked with children.[244]

3 Kevin Dowling (*Sunday Mirror*) provided a copy of a telex he had sent to his editor in 1973. Having said that according to Mr Wallace the CO of Tara was William McGrath and a homosexual the telex continues:

> "McGrath apparently uses a non-existent evangelical mission as a front to entice young Protestant men into homosexuality. Once in they are potential blackmail victims and soldiers of Tara."[245]

4 Jim Campbell (*Sunday World)* said he received two documents from Mr Wallace through the post in the mid-1970s. It would appear that no mention was made of abuse of children in Kincora at that time.[246]

5 Conor O'Cleary (*Irish Times*) said that he had no recollection of any discussion with Mr Wallace about Kincora, or any other boys' home.[247]

351 At page 16 of his submission to the Inquiry of 9 September 2016 Mr Wallace provided the following explanation for not naming Kincora to journalists.

> "The name "Kincora" was not used in any of the documents or briefings produced by Information Policy because I was specifically instructed not to for reasons associated with the RUC. In any event, the name "Kincora" had no significance whatsoever for the press in the mid-1970s. The address of the property was believed to be sufficient to give the press a clear indication of the building and what it was used for. I believe the redacted words on the document were "Faith House". McGrath called his previous residences by that name, but I seem to recall that he did not use that name after he moved from Greenwood Avenue to the 188 Newtownards Road, hence the removal of the name from the briefing sheet.
>
> The Inquiry appears to be confused over the two press briefings used by me. One document was designed to be given to the appropriate press contacts, the other one, for legal and security reasons, was only

244 KIN 30079.
245 KIN 30231.
246 KIN 30081.
247 KIN 124648 and 124649.

to be referred to during un-attributable briefings. It was not designed to be given to the press. In other words, if a journalist claimed to have been given the names of any of the non-Tara personalities, such as Thomas Passmore, or William McGrath's address or telephone number, then that information would have come from the second version. We were aware that some journalists had very close relationships with the RUC and that information obtained from us would almost certainly be passed to the police. It had to appear that we were focusing on William McGrath and Tara as paramilitary entities, and not on allegations of sexual abuse at the hostel."[248]

352 The assertions in it that the focus was on William McGrath and Tara as paramilitary entities, and not on allegations of sexual abuse at the hostel, are irreconcilable with the account he gave in 1982 when he says he did pass the information he received from the social worker to journalists. The accounts by the five journalists in 1982 and 1985 do not support the 1982 account either.

353 We have already examined the document Wallace provided to witness C before the latter prepared his report of 4 July 1974. Mr Wallace's document made no reference to Kincora, nor to McGrath's employment at Kincora, nor to McGrath being believed to sexually assault residents in Kincora.[249] We can see no reason why, if Mr Wallace possessed the information he says he possessed about abuse at Kincora in 1972 and 1973, he did not refer to those matters when he gave information to the Major who was in charge of the HQNI Intelligence Branch desk in G Int responsible for Protestant terrorist or extremist groups.

The 1974 investigation leading to Mr Wallace's removal from Northern Ireland

354 We have already noted that Mr Wallace claims that he was forced out of Northern Ireland as a result of a dispute with the Security Services over what he termed the "Kincora Boys' Home Scandal in Belfast".[250] If he were forced out of Northern Ireland for that reason that would be an important matter supporting his credibility. For that reason we now consider the evidence relating to the events which led up to his dismissal in order to establish why he was dismissed.

248 KIN 124648 and 124649.
249 KIN 2512516.
250 KIN 122004.

355 As we have previously observed, Mr Broderick's evidence to the CSAB in 1975 was that Mr Wallace was highly regarded by his colleagues for his energy and professionalism. As Mr Wallace justifiably points out, his annual confidential reports that were placed before the CSAB in October 1975 show that was the case. For example, in 1972 it was said that he "continues to demonstrate that his talents in the PR field are of the very highest standard". In 1974 "his total dedication and sheer professionalism" were commended.[251]

356 However, some aspects of Mr Wallace's conduct attracted unfavourable comments from military personnel in 1974. In July 1974 there was a query whether he had gone to Hungary with a parachute team. At that time Hungary was a Communist country and as a civil servant Mr Wallace required permission to go there.[252] Mr Broderick pointed out that Mr Wallace had notified him of the trip, but the venue had been changed to Austria at the last minute.[253] Mr Wallace duly went on holiday but did not return as scheduled. Mr Broderick recorded Mr Wallace's explanation that he had missed his flight (presumably to Austria) at Shannon, gave up the idea and had an ordinary holiday in the Republic of Ireland. Mr Broderick felt that disciplinary action was not appropriate.[254]

357 Whilst the matter was relatively unimportant, indeed trivial, that was not the way it was viewed at the time by the Command Secretariat at HQNI to judge by comments in a letter of 3 October 1974. The writer said that he would not have recommended Mr Wallace for the promotion which he had by then received to Senior Information Officer, describing Mr Wallace as having "shown himself to be irresponsible to say the least", and that he had warned CM (Civilian Management) of Mr Wallace's irresponsibility in July.[255] Civilian Management was that part of the MoD responsible for civilian employees such as Mr Wallace, and these comments are an indication that not everyone at HQNI may have shared the high opinion of Mr Broderick and others of Mr Wallace.

358 Not everyone at Army HQ was as impressed by Mr Wallace as Mr Broderick. Mr Hugh Mooney served there on secondment from the Information Research Department (IRD) of the Foreign and Commonwealth Office

251 KIN 104047.
252 KIN 190061.
253 KIN 190062.
254 KIN 190064.
255 KIN 190065.

from 1971 until 1973. In later years Mr Mooney became disenchanted with Mr Wallace for a number of reasons, and approached the FCO for advice and assistance in how to deal with what he perceived as allegations made by Mr Wallace which were damaging to Mr Mooney. On 9 April 1990 Mr Mooney met Miss Spencer, an Assistant Under Secretary in the FCO. In her note of their discussion she recorded Mr Mooney's views on Mr Wallace, on Clockwork Orange and on Kincora.

> "5 Wallace was officially a member of PR but was used by IP when necessary to exploit stories. He squared his contacts with IP within the PR system and the two to some extent became enmeshed. Mr Mooney now believes that Wallace played one side against the other. He was a civilian but involved on the fringes of the Army in every way possible. He was very active in making contacts ("a great runner-around") who never realised the importance of timing a story. Ultimately Wallace seemed to be fighting what he saw as the Army's battles against everyone, including other Government departments, though not at the Army's behest. Wallace had had a pretty freehand after promotion (to Senior Information Officer – technically after Mooney had left Belfast, but in practice changes seem to have taken place before his departure).
>
> 6 Mr Mooney said that he had known nothing about Clockwork Orange. He recalled one meeting referring to the Kincora Boys' Home, but no reference to it as a homosexual honey-trap run by MI5. IP had only been interested in Tara, the alleged protestant paramilitary group."[256]

359 Whilst Mr Mooney's comments must be treated with caution because of his ill feeling towards Mr Wallace, the picture he painted of Mr Wallace having "a pretty free hand" both before and after his promotion to SIO echo what others were to say about the latitude extended to Mr Wallace in 1975. Mr Mooney's recollections of references to Kincora are consistent with the contemporary references by the MoD, MI5, SIS and RUC Special Branch records that we have already examined.

360 Mr Mooney's contemporary comments on Mr Wallace were more favourable. On 20 March 1975 he recorded in a memorandum that a conversation with an MoD official the day before resulted in his learning that Colin Wallace was leaving Northern Ireland and had been disciplined

256 KIN 200535.

in some way following an investigation into the leaking of information to the press.

> "4 I was somewhat shattered to hear this, since, like Brigadier [MOD Official] I considered Wallace the most valuable member of the Army Information Services, who throughout the time I was there launched many very damaging stories against the IRA and other extremists."[257]

361 The IRD Official to whom he addressed the memorandum noted on 24 March 1975 that "...Mr Mooney fears that [Mr Wallace] may have been the victim of a "terrible injustice" since, in his view, he may have received insufficient guidance from the Army IP Section on the clearance of classified material for unattributable briefing."[258]

362 The reference in the letter of 3 October 1974 to "Wallace is still under investigation" may have referred to the matters we now consider. On 24 September 1974 the *Times* quoted from what it described as a "confidential memorandum within the Northern Ireland Office", that was said to have been written just before Robert Fisk's:

> "Disclosures in the *Times* of August 31 and September 2 of plans to expand local part-time security forces and to withdraw 1000 British troops from Northern Ireland".

The NIO believed the section quoted in the article to be;

> "verbatim from an internal minute classified CONFIDENTIAL sent by the NIO Security Operations Division located in Dundonald House Belfast. There were two addressees and nine copy addressees. It is an accurate word-for-word-quote from that document".[259]

363 Such was the concern of the NIO about the nature of this leak that, apart from instituting an investigation within the Belfast and London offices of the NIO, the Permanent Under Secretary, Sir Frank Cooper, asked the head of the Security Service, (Sir Michael Hanley) to provide an officer from MI5 to handle the investigation. Sir Frank Cooper wrote to Sir Douglas Allen, the recently appointed Head of the Home Civil Service, on 25 September 1974 to inform him of the investigation. He explained his reasons for asking the Security Service to conduct the investigation in this way.

257 KIN 200507.
258 KIN 200508.
259 KIN 102002.

> "In view of the extremely unusual and delicate circumstances in which we are operating and the special seriousness which we must attach at the present time (following the recent assassinations of a Judge and Resident Magistrate and further threats to judicial officers and civil servants) to the unauthorised disclosure of sensitive information on law and order matters in Northern Ireland, I have already asked the Security Service for their assistance in conducting the necessary investigations, and I would be most grateful for all help which Michael Hanley, to whom I am copying this, can give us. In these special circumstances, and because my own staff are so fully extended, I would greatly appreciate it if an Officer from his Service could handle the investigation as an exception to what of course I understand is the usual advisory role. Speed is important."[260]

The letter was copied to Sir Michael Cary, the Permanent Under Secretary of the MoD.

364 When considering the reaction of the Northern Ireland Office to this leak it has to be remembered that the terrorist activity was continuing at a very high level. The reference in the letter to the assassinations by the IRA of members of the judiciary was to the murders of Judge Conaghan QC and Martin McBirney QC, a Resident Magistrate, at their homes on 16 September 1974. On the wider political front the Ulster Workers Strike brought about the collapse of the Northern Ireland Power Sharing Executive, and the Prorogation of the Northern Ireland Assembly at the end of May 1974. We consider that the Government was entirely justified in regarding "the unauthorised disclosure of sensitive information on law and order matters in Northern Ireland as warranting action at the highest level, and the instigation of an investigation. That it was being addressed at the highest level, i.e. Permanent Under Secretaries of two departments, enlisting the assistance of the Director General of the Security Service and reporting the matter to the Head of the Home Civil Service demonstrates the level of concern within Government at the time.

365 It would appear from comments made by Ian Cameron in May 1987 when he took up his post at HQNI as ASP that he had concerns about AIS in general, and Mr Wallace in particular, even before Mr Wallace came under suspicion in the MoD leak inquiry set in train at the request

260 KIN 102002.

of Sir Frank Cooper of the NIO in late September and which we examine below. A letter from MI5 to SIS on 18 December 1989 contained the following reference:

> "I must tell you that at a late stage we discovered a note of May 1987, interestingly by [MI5 Officer 1] himself, of an informal conversation he had with Ian Cameron [SIS Officer B]'s successor as ASP at HQNI) in which Cameron had said that on arrival at HQNI in June 1974 he had found that [SIS Officer B] had had dealings of some sort with WALLACE. Being the cautious man he was, Cameron had then issued instructions to his staff not to speak to WALLACE"[261]

366 In 1990 Ian Cameron confirmed that he gave these instructions when he spoke to MI5 Officer 1 not long before 12 March 1990. On that date an SIS Officer made the following note of what MI5 Officer 1 told him about the conversation.

> "2.[MI5 Officer 1] told me that he had been to see Ian CAMERON recently. They discussed CAMERON's recollection of possible [SIS Officer B] – WALLACE contact in the light of CAMERON's earlier conjecture [MI5 Officer 2] letter of 18 December to [SIS Officer O] that [SIS Officer B] had some dealings with WALLACE.
>
> 3. CAMERON took over from [redacted] in July 1974 and had a handover lasting only three days, at the end of which he was not much the wiser. It was only after [redacted]'s departure that CAMERON discovered some file which [redacted] had kept and which contained details of a few journalists. There wasn't very much in the files but as CAMERON also heard that [redacted] had been in the habit of meeting journalists he suspected that [redacted] had been studying journalists for some undisclosed purpose. [the references to "redacted" are to SIS Officer B].
>
> 4. It was because everybody at Lisburn regarded WALLACE as the local guru on every subject, and because whenever anything cropped up the immediate reaction was to 'ask WALLACE', that CAMERON told his staff to keep well away from the Army Information Services and from WALLACE in particular. This of course was well before WALLACE had fallen under any sort of suspicion."[262]

261 KIN 3592.
262 KIN 3596.

367 Ian Cameron's directions suggest that even before Mr Wallace fell under suspicion Ian Cameron's instruction to his staff would have insured minimal contact between Mr Wallace and MI5 Officers.

The MI5 investigation of the leaks

368 It is likely from the reference in the letter of 3 October 1974 to Mr Wallace being "still under investigation" that he very soon came under suspicion as a possible source for the leak. The Security Service investigation culminated in a seven-page report of 9 December 1974. The full report can be seen at KIN 102004 to 102010. The report examined seven leaks in all. The first, described as "Leakage number 1" related to the items referred to in *The Times* of 31 August and 2 September 1974 referred to in Sir Frank Cooper's letter of 25 September 1974. Three others related to leaks believed to be connected to the journalist Robert Fisk in 1973 and 1974. Three further leaks were believed to have occurred after Leakage number 1. Two of the three, leakages Number 6 and Number 7, must have occurred after the publication of the quotation in *The Times* of 24 September 1974. In other words, the report established that further leaks had taken place, the most recent being leakage Number 7 relating to an article by Robert Fisk in *The Times* of 5 December 1974.

369 The report contained the following comments on Mr Fisk and the concerns of the Army that "his indiscretions could lead to loss of life".

> "Fisk emerges from the investigations as a competent and highly ambitious reporter who is determined to make his name professionally in Northern Ireland. He is highly regarded by the Times management and hopes to be rewarded for his work in Belfast with an important foreign posting. Fisk prefers to exploit his own contacts rather than use the press facilities provided by Stormont Castle and Lisburn; he also enjoys needling the authorities when the opportunity arises. The Army have expressed fears that under some circumstances his indiscretions could lead to loss of life."[263]

370 The report suggested that Mr Wallace was "a strong candidate" as the principal source of Mr Fisk's information.

> "It is of course possible that these several leakages of information were from a number of sources. But someone who figures as a

263 KIN 102004.

common factor in all the incidents and must be considered a strong candidate as the principal source of Fisk's unauthorised information and of leakage Number 1 in particular is Collin [sic] Wallace, Information Officer in the Press Office at HQNI Lisburn."[264]

371 Under the heading "Future Action" the report concluded with the following passage.

"It can be seen that the evidence for WALLACE being a source of unauthorised disclosure to FISK is all circumstantial, although its cumulative weight is strong. For his involvement in some of the leakages to FISK WALLACE might be able to produce an explanation compatible with a generous view of his discretion as Information Officer (as with the disclosure of the Blue Card). But the pattern of the relationship between him and FISK and, in particular, its clandestine elements, are very difficult to reconcile with innocence. In an accompanying note the possible courses of action to deal with this situation are examined."[265]

372 The accompanying note referred to, also dated 9 December 1974, suggested three possible courses of action "subject to the decision by the Attorney General". The reference to the Attorney General was because his consent would be required if a prosecution were to be brought against Mr Fisk under the Official Secrets Act. Therefore, whether the other possible courses could be adopted depended upon whether the Attorney General would consent to a prosecution, or would be content if the matter were to be dealt with administratively. The "possible courses document" suggested three options.

1 To leave Mr Wallace where he was and continue the investigation.

2 To now challenge Wallace as being the source of Fisk's information.[266]

3 The removal of Mr Wallace from his post at HQNI.[267]

373 Following receipt of the Security Service Report and accompanying note Sir Frank Cooper wrote to Sir Michael Cary, the Permanent Under Secretary of the MoD, on 11 December 1974. He explained that there was a "cumulative weight of evidence" that Mr Wallace was a source

264 KIN 102006.
265 KIN 102010.
266 KIN 102019.
267 KIN 102021.

of leakage to Robert Fisk,[268] and having considered the three courses of action suggested by the Security Service, asked whether Sir Michael would:

> "agree to arrange for Wallace's posting away from HQNI as soon as possible, and that this should be done without confrontation".[269]

374 Sir Frank Cooper emphasised the need for a speedy action.

> "From NIO's point of view our overriding objective must be to eradicate quickly the source of FISK's access to classified information. I should say at this point that the GOC has been brought fully into the picture by the Head of [DCIS Staff], and would also take the view that steps be taken urgently to stop any further potential source of leakage."[270]

375 The meeting between Sir Michael Cary, Sir Frank Cooper, the Director General of the Security Service and the Deputy Under Secretary in the Ministry of Defence responsible for Civilian Management on 17 December 1974 decided to adopt the third option. It was decided that Mr Wallace would be given the choice of moving to a vacant post in the North West District based at Preston in Lancashire. If he did not agree to go to the GOCNI Lieutenant General Sir Frank King would see him, obviously in an effort to underline the necessity for him to accept the posting. If Mr Wallace refused to accept the posting then action would be taken by Civilian Management. What that might be was not spelt out, but it is clear from subsequent developments that this would result in Mr Wallace being forced to resign.[271]

376 On 24 December 1975 (Christmas Eve) Mr Wallace was interviewed and offered the posting to Preston. He explained why he did not wish to accept for both career and family reasons, but was told that if he did not accept the move the Ministry of Defence would ask for his resignation. He asked for, and was given, time to consider the matter until early the following week.[272]

377 By 3 January 1975 Mr Wallace had not given his response, and the delay in resolving this matter clearly concerned the NIO. The documents

268 KIN 103323.
269 KIN 103325.
270 KIN 103323-103324.
271 KIN 102022 and 102023.
272 KIN 102024 and 102025.

show that the NIO was pressing the MoD very hard, as can be seen from the following note of the NIO views made on 3 January 1975.

> "There were now two further important considerations [John Waterfield] of the NIO wished to put forward in favour of rapid action. The first was that very delicate negotiations were now in progress which could be sabotaged by premature disclosure. The second was that NIO owed a report to Number 10 on the previous leaks which they were now in a position to make. They really could not report that they had conclusively established the source of the leaks but were unable to take prompt action accordingly. Waterfield also told me that he had received confirmation of a new leak through the same channels (the helicopter story)."[273]

378 The reference to "very delicate negotiations [which] were now in progress which could be sabotaged by premature disclosures" very probably referred to efforts that were being made by the Government to persuade the Provisional IRA to extend the Christmas cease-fire, which the IRA had announced on 20 December 1974, to last from 22 December to 2 January. That cease-fire had been extended by the Provisional IRA on 2 January to 17 January. Although the IRA planted four bombs which exploded in London, and 19 people were injured in another explosion in Manchester, on 9 February 1975 the Provisional IRA announced an indefinite cease-fire to begin the following day.

379 These, and other important occurrences, were all taking place at the time of the events described in this part of the report and we are satisfied that the Government was entitled to take a very serious view indeed of the disclosures that were being made, and to take action to identify the source(s) of the leaks and to attempt to prevent further leaks.

380 By 7 January 1975 Mr Wallace had agreed to accept the posting to Lancashire, and arrangements were then made relating to his travel back to Northern Ireland from time to time to visit a sick relative, and for him to hand over his HQNI post to his replacement and to travel to England on 4 February 1975.

381 However, prior to Mr Wallace's move to England the MoD was informed that Mr Wallace was believed to be in contact with Robert Fisk, and to have promised significant information to him. The Security Service

273 KIN 102026.

provided the Inquiry with a gist summarising the contents of the material that became available.

> "In January 1975 reliable information obtained by the Security Service in the course of a leak inquiry indicated that Colin Wallace intended to remain in contact with the journalist Robert Fisk after Wallace's departure from Northern Ireland, and that he promised to provide Fisk with a significant news story."[274]

The Inquiry has examined the documents to which the gist relates and is satisfied that the gist is a correct statement of the content of those documents.

382 In his 9 September 2016 letter to the Inquiry Mr Wallace confirmed the accuracy of that information when he stated:

> "It is correct that I was going to release a sensational story to Robert Fisk. Indeed, I did release it as part of "Clockwork Orange" and with the full agreement of my superiors. It was probably the last piece of Psy Ops work I did before leaving Northern Ireland and involved demonstrating not only how the IRA obtained arms and money from the USA, but also some business people and organisation in both Northern Ireland and the Irish Republic, who were involved."[275]

We examine his reference to Clockwork Orange later.

383 In the previous paragraph of his letter, Mr Wallace made the following points.

> "Setting aside that fact that my role was to "leak" information to the press, neither MIS [sic] nor any of my superiors ever questioned me about such an allegation. Moreover, if I had been guilty of such an activity, it is simply not credible that I would have been permitted to retain my security clearance and be offered a post at the same rank in another Army HQ in England."

384 The events that we have described relating to the leak Inquiry make it very clear why Mr Wallace was not questioned by MI5 or his superiors. To have done so would have revealed to him the nature and extent of their concerns and that was something they understandably did not wish to do. The action they took was to permit him to retain his security clearance by offering him a post at the same rank at Preston as part of

274 KIN 4213.
275 KIN 124669.

a process designed to avoid him suspecting that the real reason for his posting was because he was suspected of leaking information to Robert Fisk. The true reasons for moving Mr Wallace to Preston could not be explained to him, and so it was necessary to provide him with reasons for the move which were misleading and so untrue.

385 There was strong circumstantial evidence that it was Mr Wallace who was providing Robert Fisk with at least some material which the Army understandably believed to be damaging, and was intending to pass further information to Robert Fisk. As he now admits, he also intended to provide Mr Fisk with "a sensational story" before he went to Preston and this related to the events surrounding his arrest to which we now turn. Subsequently he admitted to Mr Groves that he had supplied Robert Fisk with information about helicopter spares.[276]

Mr Wallace's arrest

386 In preparation for his move to Preston, arrangements were made for Mr Wallace to hand over all documents to his successor. On the evening of 4 February 1975 Mr Wallace left Lisburn to travel by boat to take up his position in Preston. At some stage during the day before he left for the boat he left HQNI and drove to 6 Harry's Road, Hillsborough, where he expected to find Robert Fisk. Mr Fisk was not there. Mr Wallace then put a bundle of papers (referred to hereafter as "the document") through the door and left for the boat. 6 Harry's Road was the home of Prof Green, with whom Robert Fisk had been staying for some time. Prof Green was away that weekend, and his next door neighbour's wife looked after the house for him and kept it clean. She told the police that on the afternoon of Tuesday 4 February 1975 she went to number 6 intending to tidy but found that some papers were blocking the door. She had to move the papers to open the door and when she lifted them she saw "Restricted" on every page, and references to the IRA. She was alarmed and took the papers next door to her house and showed them to her husband when he returned from work later that afternoon. He was an RUC Constable and he immediately alerted his superiors. An investigation was immediately set in train and the form it took was described by SB 11 in an interim report he prepared on 10 February 1975.[277]

276 KIN 102033.
277 KIN 50963-50964.

387 The next day police went to 6 Harry's Road and spoke to Mr Fisk. He was shown the document and denied having any knowledge of it or who had left it there. He was not prepared to make a statement to the police without the advice of his editor and of his newspaper's legal department. It seems that Mr Fisk went to Dublin believing that the house would be searched, having gathered up all his papers, including restricted documents, and putting them in his car. That at least was the account he gave to Mr Gilliland, the Chief Information Officer of the NIO.[278]

388 On 5 February 1975 SB 11 was flown to Preston where he briefed SB 12 of Lancashire County Constabulary Special Branch. On 6 February 1975 both officers were given background information on Mr Wallace by an MI5 Officer. SB 11 and SB 12 then questioned Mr Wallace who made a written statement under caution (the first statement). In the first statement he admitted going to 6 Harry's Road on 4 February but strenuously denied leaving any documents at the house.[279]

389 On 11 February 1975 Mr Wallace was in London and asked to see Mr Groves, the Chief of Public Relations at the MoD. When Mr Wallace saw Mr Groves, he told Mr Groves that he had in fact delivered the document to the house for Fisk. Mr Groves advised him to tell the police the truth at the earliest opportunity. Mr Wallace said initially that the document was not "Classified", but when Mr Groves pointed out that it was "Restricted", Mr Wallace agreed that was a classification. When he was asked why he denied putting the document through the letter-box when he was interviewed by the police, Mr Wallace replied,

> "One of the policemen who interviewed me in Lancashire was an RUC Officer. I did not feel that I should reveal to the RUC information about the Army's information policy activities".

390 Mr Groves also told him that he would have to inform the Permanent Under Secretary, to which he noted Mr Wallace as replying,

> "I understand. I have not given Fiske [sic] any other classified document. I did tell him about the shortage of spares for helicopters in Northern Ireland."[280]

278 KIN 50933.
279 KIN 50949-50950.
280 KIN 100121.

391 On 12 February 1975 Mr Wallace was again questioned by SB 11 and SB 12 and made a further statement (the second statement). In the second statement he started by saying that he wished to clear up one or two points following the previous interview, saying he,

> "was not at liberty to give you the full facts of the matter because of security implications".[281]

392 Mr Wallace explained in the second statement that he had decided to give the document to Fisk in an effort to demonstrate,

> "that the Army was not involved in Black Propaganda activities".

He concluded by saying,

> "My handling of this incident may seem irregular, however, in the course of my job I frequently had to adopt unconventional methods to influence the press or plant stories in support of Security Forces activities. I have never given classified information or documents to any journalist except with prior clearance."[282]

393 On 12 March 1975 Mr Wallace was again interviewed by RUC officers and proceeded to explain in considerable detail how he said the Army did engage in black propaganda. He said he had two jobs.

> "I had two jobs – my official one as Head of Productions for Public Relations, HQ, Northern Ireland, was my white or front job. My second job was unattributable briefing and psychological warfare known as Psyops. This was my black job."

394 One of the things he described was getting a Republican paper or leaflet "and we would then produce a doctored version which we then distributed in republican areas and also in overseas areas especially in communist countries and America".[283]

395 At this point we observe that not only did Mr Wallace lie to the police in the first statement, but by his own account he was saying in the second statement that he was attempting to deceive Robert Fisk in to believing that the Army did not in fact engage in black propaganda when according to Mr Wallace, that was what part of his job involved.

281 KIN 50951.
282 KIN 50953.
283 KIN 51016.

PART ELEVEN

The decision to dismiss Mr Wallace

396 The document which Mr Wallace put through the letter-box at 6 Harry's Road was the text of an IP/PR Presentation prepared for what was described on the front as the "CLF's Study Day 31 Jan 1975". The full document can be found at KIN 102035 to 102064. It contained a detailed explanation of the Army's approach to taking what it described as "the propaganda initiative".[284]

397 The RUC Report to the DPP on their investigations dated 19 March 1975 contained the following observation from the Chief Superintendent who forwarded the report.

> "Although the official Army view is that the actions of Wallace in relation to the document in question was [sic] totally wrong and would never have been approved by them, nevertheless, the investigation officers whilst speaking to Lt.-Col Railton, General Staff Officer, Information and Planning, HQ, NI, gained the impression that he was of the opinion Wallace's actions were more an error of judgement than criminal."[285]

Lt Col Railton was Wallace's superior and if that was a correct assessment of his view by the RUC, that view was certainly not shared by more senior officers. It is a measure of the importance that the Army attached to this whole matter that the CGS – the Chief of the General Staff and therefore the professional head of the Army – wrote to the Permanent Under Secretary of the MoD about this on 25 February 1975. The relevant portions of the CGS's minute are as follows.

> "3 Because of its specialised purpose and limited audience it is, emphatically, not the kind of document which anybody would wish to see communicated to the press – any more than a minister would want to see reported, say, an informal debrief to his senior officials of an exchange with his colleagues, or I would my obiter dicta in the Chiefs of Staff Committee or ECAB or you would your franker asides at one of your weekly meetings with your own senior staff.
>
> 4 To my mind the facts [sic] that Wallace should have selected a document of this kind for disclosure to a journalist adds a new

284 KIN 102035.
285 KIN 50971.

dimension to his culpability. Straightforward unauthorised disclosure is quite bad enough. But to lift a script of a colleague's remarks on a privileged occasion is worse, to the extent that it superimposes [on] an official impropriety a total lack of the human qualities of trustworthiness and discretion upon which relationships between colleagues depend.

5 With Frank King [the GOCNI] I feel strongly that, if the evidence is sufficient, Wallace should be prosecuted. However this turns out to be it is obvious that behaviour of this kind makes him an entirely impossible colleague in any environment, official or other."[286]

398 When their investigations were complete, the RUC submitted their report to the Director of Public Prosecutions in Northern Ireland. As the offences being investigated may have been committed under the Official Secrets Act the consent of the Attorney General was required to any prosecution and the papers were passed to him. On 14 May 1975 his office informed the DPP that the Attorney General would not consent to a prosecution.

"The Attorney General is of the opinion that the interim report discloses clear evidence of an offence under section 2 of the Official Secrets Act 1911. Both the Attorney General and its predecessors have felt it proper, in exercising their discretion on the granting of a consent to a prosecution under section 2, to take account of the circumstances of the offence, the nature of the document or information which has been disclosed, and the balance of public interest. Further, the Attorney General has in mind the recommendation of the Franks Committee in this regard. Having considered these factors, including the probability that the public interest might be better served by disciplinary proceedings than by a prosecution, the Attorney General has decided that he would not consent to a prosecution in the present case."[287]

The DPP then issued a direction to the RUC that there should be no prosecution.

399 This decision formally cleared the way for Mr Wallace to be dealt with administratively. On 30 April 1975 Sir Michael Cary, the Permanent Under Secretary of the Ministry of Defence, wrote to his Secretary of

286 KIN 102034.
287 KIN 100189.

State that the Attorney General felt legal action was inappropriate, and in any event unlikely to succeed. The Attorney General felt that the appropriate course would be for departmental disciplinary action to be taken against Mr Wallace.[288] The agreement of the Secretary of State was transmitted on 9 May 1975.[289]

400 With the submission to the Secretary of State of 30 April 1975 was sent Annex B, a list of what were described as "Examples of Information Policy Activities of the Army Information Service known to Colin Wallace". Six episodes were described, one of which was "The Clockwork Orange".[290] We return to Clockwork Orange later.

401 By this time Ian Cameron had prepared the very detailed Damage Assessment to which we have already referred. Its full title was:

> "Damage assessment on disclosures of information policy made by Mr Colin Wallace following his suspension from duty in December of 1974."[291]

The Inquiry has examined the full text of the Damage Assessment. The Damage Assessment also referred to various incidents involving Mr Wallace. At KIN 190198 Ian Cameron set out in some detail under the heading "Assessment of the Extent of Wallace's Discretion" a number of factors he considered relevant. He concluded:

> There can be no doubt that, whatever his motive for doing so, Wallace in passing a classified document to Fisk without prior authority, must have been aware that he was exceeding his discretion, was breaching a departmental ground rule, and was in contravention of his security regulation. Moreover, what he passed was not the kind of document which would in any circumstances be released to the media."[292]

That succinctly summarised the view of the officials who considered Mr Wallace's conduct.

402 We have considered these events in some detail because of the allegation Mr Wallace has made that he was removed from Northern Ireland because of what he knew about Kincora. Nowhere in any of the documents or correspondence connected to the circumstances leading

288 KIN 102065.
289 KIN 102071.
290 KIN 102070.
291 KIN 190191.
292 KIN 190198.

up to Mr Wallace's transfer to Preston, nor in the police investigation, nor in Annex B or in the episodes considered in Ian Cameron's damage assessment, is there any reference whatever, either direct or indirect, to McGrath, Kincora or to the sexual abuse of children. There is nothing to support Mr Wallace's allegation that he was removed from Northern Ireland because of his knowledge of, and actions in respect of, Kincora. The overwhelming evidence is that he was transferred to Preston and then arrested and ultimately dismissed because there was concern at the very highest levels that Mr Wallace was engaged in leaking important information and classified documents to journalists and to Robert Fisk in particular. He was believed to have behaved in a completely improper manner by doing so, and, whatever latitude he had been given, or had been able to exercise, he had behaved in a manner that meant he could no longer be regarded as a trustworthy employee of the Ministry of Defence. We have no doubt whatever that his dismissal was for those reasons and those reasons only.

Colin Wallace and the CSAB

403 Following the decision by the Attorney General, Mr Wallace was served with four disciplinary charges, and in accordance with Civil Service procedure was given the opportunity to make representations to Mr Groves. This occurred on 30 May 1975 (and not 10 May as mistakenly stated on the summary note). Afterwards Mr Wallace was provided with a copy, to which he made a number of amendments on 5 June 1975. The amendments were accepted by Mr Groves. Mr Wallace also provided an additional short statement. The note and other documents are to be found at KIN 102075 to 102084.

404 Given the outcome of his subsequent appeal to the CSAB and what was disclosed about the approach by the MoD to the Chairman, and then the deputy Chairman, of the CSAB before the hearing of Mr Wallace's appeal actually took place, it is unnecessary to examine the details of what Mr Wallace said on 30 May 1975. The following points are sufficient.

1 He accepted that the document he left for Robert Fisk was a classified document. He said he did so to safeguard IP Operations.[293]

293 KIN 102077.

2 He accepted that he had untruthfully told the RUC that the last time he had seen the document it had been in his in-tray.[294]

3 Any information he gave to Robert Fisk was on the basis that it would be "treated as 'off the record' or in specific parts, 'unattributable'".[295]

4 On 25 June 1975 he was informed that two of the four charges against him had been proved and he was to be dismissed from his employment in the Civil Service.

> "I regret that I have to inform you that the first two charges against you – namely the unauthorised retention of a classified document and the improper passing of it to a person not authorised to have access to it - have been held to be proved. A most serious view is taken of these breaches of trust by an officer in the position which you held. It has accordingly been decided that you should be dismissed from your employment in the Civil Service."[296]

He was told that it had been decided to take no action on the third and fourth charges and was informed of his right to appeal to the Civil Service Appeal Board (CSAB). In the interim he was suspended without pay from 1 July 1975.

405 Mr Wallace exercised his right of appeal, and after a hearing on 17 October 1975 the CSAB upheld the dismissal, but recommended that,

> "…having regard to his previous good record of service, if Mr Wallace wishes to offer his resignation we recommend that the Department should accept this as an alternative to dismissal."[297]

The MoD and Mr Wallace accepted the suggestion, and on 27 November 1975 he resigned with effect from 31 December 1975.

406 A number of aspects of the CSAB proceedings require comment. The first is that the MoD approached the Chairman of the CSAB before the hearing, and secretly briefed him about the background of the dismissal. The first stage in the process of briefing the Chairman occurred on 3 July 1975 when the Permanent Under Secretary of the MoD spoke to the

294 KIN 102078.
295 KIN 102084.
296 KIN 102085.
297 KIN 102113.

Chairman and sounded him out as to whether he, Sir John (Jock) Shaw, would find it useful to be briefed about the general background to the case. Writing to the Director General of MI5 the next day, Sir Michael Cary said that in anticipation of the appeal to the CSAB

> "...I had a strictly private and personal word yesterday with Jock Shaw, the Chairman of the Civil Service Appeals Board. I started out by:
>
> a) Rehearsing the charges against Wallace.
>
> b) Outlining in the most general terms the Wallace's connection with "information policy" in Northern Ireland.
>
> c) Explaining that both the circumstances and the nature of the man made it possible that the hearing would be attended by damaging publicity.
>
> I went on to say that I had asked Jock for this meeting for two reasons. First, while we had no wish to embarrass him by pressing on him information which did not relate strictly to the charges and would not be used in "Open Court", the fact was that, as he no doubt realised, the formal charge was merely the tip of the iceberg and, if you would find it useful, I would be prepared to consider arranging for him to have a briefing on the general background to the case. I added that the decision was not up to me since other departments, such as the NIO, were involved but that if he were interested I would see what could be done."[298]

407 Sir Michael suggested to the Permanent Under Secretary of the NIO and to the Director General of the Security Service that a dossier of key documents would be put together and presented to the Chairman to read. Mr Shaw agreed to this proposal.[299]

408 Sir Michael Cary described this approach as "somewhat unorthodox", but it is clear from his letter of 4 July that the Chairman did not object to the approach.

409 On 23 July 1975 Sir Michael wrote to Sir Frank Cooper of the NIO, copying the letter to the Director General of the Security Service to confirm that the briefing had taken place. He said

> "Shaw departed saying that he had been convinced, particularly by the [redacted], that the Department's decision was fully justified."[300]

298 KIN 102087 and 102088.
299 KIN 102088 and 102089.
300 KIN 102093.

410 In the event, Mr Shaw was unable to preside at the hearing of the Civil Service Appeal Board, and Sir Leslie Williams, the Deputy Chairman of the CSAB, sat in his place. It is clear that Sir Leslie Williams had been informed of the briefing which Mr Shaw had received, presumably by Mr Shaw, and on 4 October 1975 he requested a similar briefing.[301] That briefing was given. On 12 December 1989 the Secretary of State for Defence explained to the Prime Minister that:

> "The CSAB Chairman was briefed privately, and shown evidence, that Mr Wallace was likely to have been responsible for other more serious leaks, which were never put to Mr Wallace; and it appears that he told his two fellow Assessors that he was aware of additional sensitive material but that he would not tell them what it was. So this evidence was in the minds of the Appeal Board but was not put openly to them in a way which would have given Mr Wallace an opportunity to offer a defence."[302]

411 We consider that the fact that National Security was involved did not excuse the approach that was taken. Courts and other quasi-judicial bodies have in more recent times developed procedures to deal with the difficult issues that can arise when dealing with sensitive information. For example, special advocates can now be appointed in certain circumstances. Such procedures did not exist at that time. As a later chairman of the CSAB confirmed, it had no power to hear information in camera. At the time the MoD faced a stark choice, either to reveal more information to the CSAB and to Mr Wallace, with the attendent risk that this information may be more widely disseminated, or to take the risk that the CSAB would find in Mr Wallace's favour. In that case he would presumably have been entitled to some form of remedy, such as being reinstated completely, or subject to some form of penalty such as demotion or other financial penalty, or to compensation if he were not reinstated. The Ministry of Defence chose to rest its case on a narrow basis, but to avoid the risk of losing decided to secretly brief the Chairman in order to influence the outcome of the case and so increase the prospect of a successful outcome from the point of view of the Ministry of Defence.

301 KIN 102105.
302 KIN 104008 and 104009.

412 What happened in this instance was that the processes of the Board were deliberately interfered with by the Ministry of Defence in order to ensure that the outcome of Mr Wallace's appeal was unsuccessful. We criticise all of those involved in what occurred in the strongest terms. Mr Wallace's observation in his letter to the Inquiry of 9 September 2016 that the outcome of the Inquiry was "rigged" was entirely justified.[303]

The job specification

413 Mr Wallace has been, and remains, intensely aggrieved that his full job description was not produced by the MoD at the CSAB hearing, and that the Ministry of Defence did not concede at the time, or for a considerable number of years subsequently, that he was engaged in "black" operations. For many years the MoD asserted that his job description did not include such activities.

414 In his letter to the Inquiry of 9 September 2016 Mr Wallace asserted that the real job description was approximately four or five pages in length, was shown to him in draft by Peter Broderick, and shown to him again after it had been approved and his promotion ratified. He says that there were several copies of his "secret" job description available in 1974 and suggests that it is "...very strange that my job description has apparently not been made available to the Inquiry".[304]

415 We understand the MoD position to be that whilst there was a revised job specification, it existed only in draft form, although Mr Wallace almost certainly knew,

> "...at least in general terms, the thrust of the wording of the draft covert job description, [but] probably did not see the exact wording and almost certainly was not issued with formal written Terms of Reference concerning his covert duties."[305]

On 12 December 1989 the Secretary of State for Defence explained that matter to the Prime Minister in the following terms.

> "[Wallace] had no formal directive of that kind, so far as can be seen. But such a job specification was drafted... to justify the establishment of his post and it is reasonable to assume that Mr Wallace was told what it contained, even though it was never endorsed at Ministerial

303 KIN 124640.
304 KIN 124642.
305 KIN 102918.

level. MoD did not contest Mr Wallace's evidence that such a job specification had been prepared; but nor did MoD acknowledge it or make a copy available."[306]

416 We understand why Mr Wallace continues to attach such importance to the question why his job description was not revealed to the CSAB by the MoD, and the denials for many years that there was a revised job specification, or that Mr Wallace was engaged in "black" operations. However, we consider the job specification issue to be of peripheral relevance to what Mr Wallace did or did not know about Kincora, and when he knew what he did know. At the CSAB hearing Mr Wallace's representatives explained in some detail to the Board, although in somewhat general terms, what Mr Wallace did. The passages from Mr Broderick's statements to the CSAB on Mr Wallace's behalf which we have already quoted supported the general thrust of Mr Wallace's argument.

417 We have taken what Mr Wallace has said about the job specification, and the approach to it by the MoD over the years, into account because on one view it may be said to support the wider case which Mr Wallace makes, which is that the MoD, MI5 and the Government as a whole have lied about what he did. We have taken all of this into account when examining all the material the Inquiry has obtained, and assessing the various points made by the Government through the various non-devolved departments and agencies which have been core participants in the Kincora Module.

418 When considering what Mr Wallace did or did not know about Kincora, and what he did with whatever knowledge he had, in 1974 and 1975 we took into account that he did not mention Kincora to Mr Groves at the MoD, nor did he mention it to the RUC when describing what Mr Wallace clearly regarded as the significant matters he was engaged in before his arrest, nor did he refer to it in any of the materials placed before the CSAB by him or on his behalf.

419 We examined a very large number of contemporary documents from 1974 and 1975 relating to Mr Wallace and his dismissal. As can be seen from the documents to which we have referred, and the other documents examined which have come from the MoD, the NIO, and MI5 which relate to Kincora, and in which, if Mr Wallace had the knowledge

306 KIN 104008.

of Kincora that he has claimed, we would expect to find some reference, however slight or indirect, to two matters that Mr Wallace says were of importance. These are Kincora and Clockwork Orange. So far as Kincora is concerned, we found no such material.

420 Following the first statement Mr Wallace made to SB 12 and SB 11 on 6 February 1975, and his second statement to SB 12 on 12 February 1975, Mr Wallace was interviewed a third time. On this occasion it was by SB 11 and SB 13 of the RUC at Preston on 12 March 1975. No written statement was taken on that occasion, but notes were made of the questions and the answers. We have already referred to some of what Mr Wallace said about his operations. We should point out that the note of that interview is erroneously dated 12 February 1975, when it should be 12 March 1975. That is clear from the report submitted to the DPP on 19 March 1975 by a Chief Superintendent.[307] The notes of that interview contain no reference to Tara, McGrath, Kincora or abuse of children.[308]

421 The only document Mr Wallace has put forward which he says were contemporary documents created by him are the 8 November 1974 document and a reference in a letter dated 29 September 1975, which he says he sent to Cliff Crook of the Institution of Professional Civil Servants who represented him before the CSAB.[309] We examine both of these documents later.

422 Annex B of the paper submitted to the Secretary of State listed six "Examples of Information Policy Activities of the Army Information Service known to Mr Wallace". Whilst one of these referred to Clockwork Orange, none referred to Kincora in any way.[310]

423 The Damage Assessment prepared by Ian Cameron after Mr Wallace's arrest, to which we have already referred, catalogued "Wallace's IP Activities" over some six pages. Ian Cameron observed that

> "...Grounds for embarrassment are certainly present but their significance and the extent of the potential damage involved will very much depend upon the nature and scope of what was in fact undertaken with Wallace's knowledge and what, in his particular circumstances, he would wish to disclose."[311]

307 KIN 100070.
308 KIN 51016-51019.
309 KIN 124726.
310 KIN 102070.
311 KIN 190200.

424 The Ministry of Defence subsequently agreed to provide the entire Damage Assessment in unredacted form and this will be placed on the Inquiry website in due course. The Inquiry has examined the full text of the original document, and considered the various matters described in it. There is no reference in those documents to Tara, Kincora, McGrath or the sexual abuse of children in Kincora. If there was any such knowledge on the part of MI5, the MoD or the NIO of Wallace's 8 November 1974 document at that time, we can see no reason why Ian Cameron would not have referred to it. That he did not refer to it suggests that either Ian Cameron was unaware of it, or that the 8 November 1974 document did not exist at that time. Another explanation could be that Ian Cameron felt that it was too damaging to even admit in the document that Mr Wallace had completed the 8 November 1974 document. Given that Mr Cameron did refer to Clockwork Orange, we consider it most unlikely that he would have omitted any reference to the 8 November 1974 document, or to Kincora and sexual abuse had he known of these matters.

Clockwork Orange

425 Mr Wallace has consistently placed great emphasis on the refusal by the MoD for many years to acknowledge the existence of Clockwork Orange until it admitted in 1990 that there was such a project. He relies on this denial to support his assertion that the MoD, MI5 and the Government misled Parliament and have misled this Inquiry. We have taken these arguments into account when considering Clockwork Orange, and when we assess the significance of the documents we have examined and the submissions on behalf of the non-devolved core participants.

426 When Mr Holroyd produced the GC80 document to Essex Police in August 1984 he told Essex Police that Mr Wallace sent the document "to an MI5 Officer at HQ Northern Ireland office".[312] If Mr Holroyd did say this, that information must have come from Mr Wallace, yet, as we shall see, Mr Wallace has said he did not know who received the GC80 document once it was submitted. If an MI5 Officer was the recipient, there is no record or evidence to support that. If the MI5 Officer was Ian Cameron it is surprising that he did not refer to it in his Damage Assessment because in that he referred to other matters that could cause embarrassment to the Government.

312 KIN 51074.

427 In the Damage Assessment at paragraph 56 Ian Cameron referred to Clockwork Orange.

> "56 This was the title of a project involving the 'planting' of an account of the organisation and activities of the PIRA purporting to have been written by a PIRA deserter. It was not in fact issued but it is of interest in at least two respects. It is a fair measure of Wallace's competence in the IP field and his encyclopaedic knowledge of the subversive scene in Northern Ireland. It also demonstrates Wallace's determination – with whatever intention – to take an independent line even to the point of disobeying instructions. Although, in this instance, he had been instructed not to proceed he nevertheless addressed a catchment letter in the form of a forgery to Gerard Kemp of the Daily Telegraph whose response entailed the CIO attending a meeting with Kemp in the Europa Hotel. Despite the embargo on premature action Wallace nevertheless – in advance of clearance – again acted independently by offering a story to another correspondent and in doing so enlisted the services of an NCO in the AIS. For a variety of reasons the project has not been cleared."[313]

428 We have already referred to the letter of the Secretary of State for Defence to the Prime Minister in December 1989 relating to Clockwork Orange, and to the CSAB Hearing. The Government recognised that it was necessary to correct what had been said in the past about Clockwork Orange, and a statement was made to the House of Commons on 30 January 1990 explaining what had happened.[314]

429 An internal investigation into how it was that the Clockwork Orange document had been overlooked was carried out by Mr Heyhoe, a Senior Official in the Ministry of Defence. His report can be found at KIN 103315 and following. The nub of Mr Heyhoe's conclusion was that so far as Clockwork Orange was concerned:

> "(e) When the case next came to light in 1982 it was in the different context of Inquiries over Kincora, subsequently, "Clockwork Orange" emerged by name in 1984. Neither of these subjects appeared to play any part in Mr Wallace's disciplinary proceedings in 1975.

313 KIN 190205.
314 KIN 124850-124852.

(f) The result of these developments was to leave General Staff Secretariat, an extremely busy operational division supporting the Army, to deal with a difficult personal case on a basis of incomplete records and a total discontinuity of collective memory.

(g) All this took place against a background of more than ten years' individual and organisational change inevitable in a large and complex Department of State."[315]

430 The Inquiry has examined the Heyhoe Report and the papers associated with it, including the statements from the various officials who were involved with the documents, and we see no reason to disagree with Mr Heyhoe's conclusion, that with the passage of time, changes in personnel and organisation resulting in a break in collective memory, meant that the Clockwork Orange documents were genuinely overlooked.[316] As a result, incomplete information was given to Government and on the basis of that incomplete and inaccurate information the Government took a stance on Clockwork Orange which it is now clear was unjustified. The Ministry of Defence accepted that in the statement to the House of Commons on 30 January 1990.

431 A further aspect of the Clockwork Orange matter that may be of some relevance to Kincora is whether Mr Wallace's account of his involvement in Clockwork Orange has been consistent over the years. In Paul Foot's *Who Framed Colin Wallace?* at page 113 he describes how he became disenchanted with Clockwork Orange.

> "One afternoon early in October [1974] I saw "John Shaw" from MI5. I sat having a quiet drink with him at the White Gables Hotel, near Hillsborough. At one stage, I told him I didn't want to go any further with Clockwork Orange without political clearance. He seemed surprised and suggested that I already had clearance. But I made it clear I wanted some proof that the whole programme had been seen and approved by a Minister.
>
> Of course I was pretty certain that 'Shaw' couldn't get a ministerial clearance for Clockwork Orange. I was pretty sure that no minister had a clue that Clockwork Orange even existed. But I knew I couldn't go on doing it, and I wanted to get on with other things."[317]

315 KIN 103319.
316 KIN 103315-103320.
317 KIN 5189.

432 At page 147 there is a similar assertion[318] and at page 158[319] it is stated that:

> "Colin felt, however, that after his refusal to do any more for Clockwork Orange and his testy memorandum about Tara and the boys' home in Belfast, a powerful effort was being made by MI5 to take charge of Psyops and to push him to one side in the process."

433 We are satisfied that the proper inference to draw from these passages is that Mr Wallace did no more work on Clockwork Orange after October 1974. However, he told Mr Groves on 30 May 1975 that he still had six briefings for the press to do after he left Northern Ireland, and in his letter to the Inquiry of 17 October 2016 he said that he was still engaged on that work.[320]

434 We consider there to be a significant inconsistency between the account of his involvement in Clockwork Orange contained in *Who Framed Colin Wallace?* and his accounts to Mr Groves in 1975 and to the Inquiry in October 2016.

The 1975 phone call to Social Services

435 Mr Wallace has asserted that in 1975 he made a phone call about Kincora to Social Services in Belfast. No trace of any such call has ever been found. In his recent communications with the Inquiry Mr Wallace has not volunteered any information that might assist the Inquiry in establishing whether or not such a phone call was made.

318 KIN 5206.
319 KIN 5212.
320 KIN 124812.

PART TWELVE

Mr Wallace and Kincora between 1976 and 1980

436 Mr Wallace married in 1975, and by December 1975 was living in London. On 10 December 1975 he wrote to Mr Groves thanking him

> "...for all your kindness and understanding during my recent problems. My apologies for all the embarrassment caused to you and your staff, I hope the matter now dies.
>
> Naturally I feel very bitter at the whole episode but I realise that to contest the outcome any further would not be in anyone's interest."[321]

Despite Mr Wallace's hope that "the matter now dies", from the beginning of 1976 until his arrest in 1980 for the murder of Jonathan Lewis Mr Wallace devoted considerable time and energy to pursuing various matters relating to his time in Northern Ireland in various quarters.

437 At the beginning of 1976 Mr Wallace found it hard to find a suitable post. When he applied for posts in Government departments or in public bodies the Ministry of Defence response was to give favourable comments on his duties and to give the reason for the termination of his appointment as "resignation by mutual agreement following a breach of discipline." Whilst Mr Wallace resented this, and clearly it made it very difficult for him to obtain positions in the public sector, the Ministry of Defence understandably felt that they could not recommend him for appointments in other departments. Given the circumstances leading up to his dismissal that attitude was justified. Later in 1976 Mr Wallace was appointed to the post of Information Liaison Officer with Arun District Council in West Sussex, and he and his wife moved to Arundel.

438 Between 1976 and 1980 Mr Wallace did not confine himself to his duties with the Council. Before and after his appointment he wrote to, or spoke to, many different individuals about matters relating to his dismissal and his activities in Northern Ireland. We examined the material held by the non-devolved departments and agencies, and the material sent to the Inquiry by Mr Wallace, to see whether there was anything to suggest that during this period Mr Wallace repeated the allegations contained in the 8 November 1974 document.

321 KIN 102115.

439 Early in 1976 when Mr Wallace was living in London and attempting to find employment, he approached his constituency MP, the Labour MP Roland Moyle, who at that time was a Junior Minister in the Northern Ireland Office. It appears that at that time the concerns which Mr Wallace made known to Mr Moyle related to his safety, and whether Mr Wallace could put his case about his dismissal to the Secretary of State for Defence. Mr Moyle discussed Mr Wallace's concerns with the NIO on 6 May 1976[322] and later that month.[323] The records relating to both meetings do not suggest that Mr Wallace had raised either Kincora or Clockwork Orange with Mr Moyle.

440 On 18 July 1976 Mr and Mrs Wallace paid a social visit to Mr Broderick, who was by that time working in the Department of the Environment in London. Mr Broderick described the conversation in a letter he wrote the next day to the Ministry of Defence. He recorded that Mr Wallace was considering appealing to an industrial tribunal against the CSAB decision, and identified what he described as two "grievances" held by Mr Wallace at the time. One was about the terms of his reference from the Ministry of Defence, which he felt made it very difficult for him to get a new job. The other was that Mr Wallace believed that he was being blamed "for the Army's past misdeeds", presumably meaning the Army's activities in the area of Black Propaganda. There is no reference to Mr Wallace raising Kincora or Clockwork Orange with Mr Broderick.

441 Mr Broderick's comments on Mr Wallace's behaviour at that time are revealing, particularly as Mr Broderick had spoken so strongly on Mr Wallace's behalf at the CSAB hearing.

> "I thought you ought to know that he is still, in my opinion, unable to separate fact from fiction".[324]
>
> "Wallace is just not acting rationally or responsibly."[325]

442 Mr Wallace's contacts with the Labour Government during these years were not just with Mr Moyle. In 1977 he wrote to the former Labour Prime Minister Harold Wilson MP to assure Mr Wilson that Mr Wilson's fears when he was Prime Minister that he was the subject of attempts by MI5 to discredit him were well founded. In *Who Framed Colin Wallace?*

322 KIN 102117.
323 KIN 105304.
324 KIN 102121.
325 KIN 102122.

page 179,[326] it is stated that he (Wallace) and Information Policy had disseminated information hostile to the Government and its Ministers. He gave "tasty examples" from the Clockwork Orange material, and asked for an interview in which he could put the whole story. It appears from this account that his request was turned down. We note that no suggestion was made at that time that Mr Wallace referred to Kincora or the 8 November 1974 document.

443 Mr Wallace did not confine his contacts to members of the then Labour Government, because he was in contact at that time with Airey Neave MP, at the time a Conservative Party opposition MP. Pages 172 and 173 of *Who Framed Colin Wallace?* describe the contacts between Mr Wallace and Mr Neave in 1976 during which

> "Colin happily supplied the MP with much of the information he had gleaned during his compilation of the material for Clockwork Orange".[327]

444 During these years Mr Wallace continued his contact with journalists. At page 174 of *Who Framed Colin Wallace?* there is a description of a newspaper article that Mr Wallace wrote for the Daily Telegraph on 26 October 1976 "based on the Clockwork Orange document", for which he was paid £70. Paul Foot wrote:

> "That £70 was the only tangible advantage which Colin got from his brief association with Airey Neave. He had hoped through the association to raise once more his treatment at the hands of the Ministry of Defence. Airey Neave listened sympathetically to his story, but did nothing to help."[328]

445 Mr Wallace's contacts with the press between 1976 and 1980 were not limited to this article for the *Daily Telegraph*. One of the journalists to whom he spoke in 1977 was David Blundy of the *Sunday Times.* David Blundy and Mr Wallace met on several occasions in 1976 and 1977 according to *Who Framed Colin Wallace?* They collaborated on a front-page article on 13 March 1977 headlined "The Army's secret war" which claimed the material came from "our sources", the chief of whom, according to page 175 of *Who Framed Colin Wallace?* "was Colin Wallace".[329]

326 KIN 5222.
327 Page 173 of the book, KIN 5219.
328 KIN 5220.
329 KIN 5220.

446 During an interview with the RUC on 10 December 1982 Mr Blundy told the police that Mr Wallace was one of his sources for a story he wrote about the abduction of Thomas Niedermeyer, the German Managing Director of the Grundig Factory on the outskirts of Belfast. Mr Niedermeyer was murdered by the IRA, and his body was not discovered for several years. During the December 1982 police interview Mr Blundy was asked about Kincora as can be seen from the following questions and answers.

> "Q: Did you or Wallace at any of the briefings or conversations ever mention Kincora?
>
> A: No, never.
>
> Q: Did anyone at any briefing mention Kincora?
>
> A: To my knowledge – not.
>
> Q: Was any mention made of homosexuality at any home in Northern Ireland?
>
> A: To my knowledge – no.
>
> Q: Did you have any knowledge of homosexuality in any children's home in Northern Ireland in 1973 – 1974 period?
>
> A: No."[330]

As Mr Blundy was clearly on good terms with Mr Wallace in 1976 and 1977, and received a lot of assistance from him, if Mr Wallace had the GC80 document and/or knowledge of abuse of residents in Kincora we believe he would have shared that information with Mr Blundy. He did not according to Mr Blundy.

447 After Mr Wallace was dismissed from the Army Information Service the Army believed that he was still in contact with other journalists as well as Mr Blundy to judge by a report from HQNI of 4 August 1977 which referred to Mr Blundy and Mr McKittrick of the Irish Times investigating stories on Black Propaganda and NUJ cards. The Army suspected that Mr Wallace was a source for some of the material in the press at the time.[331]

448 In June 1976 Lt Col Sillitoe made a complaint to the Press Council about the way in which *The Times* published part of a manuscript by Lt Col Sillitoe which was his private property, and which he intended to

330 KIN 30075.
331 KIN 190167.

use for a book, and had deliberately misrepresented the document as a confidential Army memorandum. We do not consider it necessary to examine the contents of this letter in detail. It is sufficient to say that Lt Col Sillitoe repeatedly refers to having provided a copy of his manuscript to a person whom he describes as:

> "a civil servant and former colleague for help with research, and that I made it quite clear to him that the material I had sent was private and for publication in a book".[332]

449 It is clear from the letter that the "civil servant and former colleague" to whom Lt Col Sillitoe referred was Mr Wallace. Lt Col Sillitoe made it clear that he believed Mr Wallace passed the manuscript to Mr Fisk, despite Lt Col Sillitoe repeatedly asking Mr Wallace to return the document. Lt Col Sillitoe alleged that not only did Mr Wallace pass on the manuscript, before he did so Mr Wallace had caused the manuscript to be typed and represented as a "report".

> "If, at some later stage, he caused my manuscript to be typed and communicated to someone else as a 'report' he was acting improperly."[333]

The relevance of this matter to the Inquiry is that, if Lt Col Sillitoe's allegations about Mr Wallace were correct, it shows Mr Wallace had had no scruples about passing other material to Mr Fisk apart from the documents and material examined in the Security Service Leak Report, and was prepared to alter a document and represent it to be a 'report' when it was not. Lt Col Sillitoe's letter to the Press Council can be found at KIN 200502 to 200506.

450 Mr McKittrick made his statement to the RUC on 25 February 1982, in which he said,

> "In 1979 I interviewed Wallace extensively about Army Intelligence matters but Kincora or McGrath were never mentioned".[334]

As Mr McKittrick worked for the *Irish Times* he might well be the person to whom Mr Wallace referred in a letter from Lewes Prison to Mr Holroyd in which he wrote on 27 May 1984,

332 KIN 200503.
333 KIN 200503.
334 KIN 30079.

> "I am also fairly certain that a Dublin journalist asked me about you in 1979/80..."[335]

Whether or not the "Dublin journalist" was Mr McKittrick, this remark shows that Mr Wallace's contacts with journalists were not limited to those who worked for United Kingdom newspapers.

451 The same letter contains a reference to Mr Wallace's "discussions with a senior conservative MP in 1979 about another matter", Airey Neave MP was such a person and, as we have seen, Mr Wallace had considerable contact with Mr Neave in 1976.

452 In his letter to the Inquiry of 27 October 2016, Mr Wallace said that he had been told by a reporter, "...in 1976, a year after I left the MoD" that the reporter had recently been given a copy of the Folio Document by an official at the NIO.[336] Although this reporter is not named, it is a further indication of the number of contacts with journalists that Mr Wallace had after he left Northern Ireland after his dismissal.

453 As we have seen, Mr Wallace has claimed that he was moved from Northern Ireland to Preston because of what he knew about Kincora, and he has claimed that in 1974 he prepared the document dated 8 November 1974. He has claimed that he was aware from 1972 of allegations that residents in Kincora had been sexually abused, and that he was very concerned about what he was told. When considering the credibility of his accounts we consider it relevant to take into account whether Mr Wallace did anything to bring what he had been told, and the information he had gathered, about Kincora and the sexual abuse of residents there to light, and to bring to justice those who he had reason to believe from what he had been told had abused residents in Kincora, and thereby prevent further abuse as well. He claims he made a phone call to social services in 1975. There is no record of such a call. By his own account he was in contact with his Labour MP about his dismissal, and with Airey Neave MP about Clockwork Orange. He wrote to a former Prime Minister. He was in contact with several journalists.

454 There is no evidence to show that despite all of these contacts over several years he did anything to alert anyone to his concerns about Kincora, nor is there any evidence to corroborate his assertions as to what he did do.

335 KIN 51079.
336 KIN 124834.

455 If Mr Wallace had been concerned about the residents in Kincora during those years we consider it was his duty to give his information to the police. If, as a result of his experiences which led to his arrest and questioning by the police in 1975, he did not trust the RUC, we see no reason why he could not have given the information, and the 8 November 1974 document, to Mr Moyle MP, to Mr Neave MP, or to the various journalists with whom he was in frequent contact. All of the evidence shows that he did not do so.

Mr Wallace's arrest in 1980, conviction and imprisonment

456 The existence of the 8 November 1974 document did not become known until 1984. Before we examine the document, and how its existence became known to the police and others, it is necessary to place the issues relating to Kincora against the backdrop of Mr Wallace's circumstances from the summer of 1980 onwards. This is because for several years he was in prison. The reasons for his conviction, and the eventual quashing of his conviction, are not relevant to this Inquiry. Throughout his years in prison, much, but not all, of Mr Wallace's voluminous correspondence related to his efforts to establish his innocence and overturn his conviction. Many of the letters he sent during this time dealt with his conviction and his efforts to establish his innocence. They also refer to other matters such as the circumstances leading up to and relating to his dismissal, Clockwork Orange and Kincora. Whilst the Inquiry has examined all of Mr Wallace's correspondence to and from the Government ministers and officials, including two Prime Ministers, MPs, the Hughes Inquiry, and others held by the PSNI and the core participants in the Kincora module, only that which we considered touched directly or indirectly on Kincora is referred to in this portion of our Report.

457 As will be apparent, Mr Wallace was, and remains, an indefatigable correspondent whose letters contain a wealth of detail. Much of what is contained in the correspondence we have examined consists of repetition of the same arguments and references. Many of the documents to which he refers, such as newspaper articles, were of little assistance to the Inquiry. We have carefully considered all his correspondence, and the documents referred to therein. We only refer to those which, in our view, are of sufficient relevance to the issues we examine in this chapter.

458 The following dates in the 1980s and 1990s form part of the backdrop to the matters that we now examine.

6 August 1980	–	death of Jonathan Lewis at Arundel, West Sussex.
18 September 1980	–	Mr Wallace was charged with the murder of Jonathan Lewis.
20 March 1981	–	Mr Wallace was convicted of the manslaughter of Jonathan Lewis and sentenced to 10 years imprisonment.
12 February 1982	–	Mr Wallace was refused leave to appeal (the first appeal)
5 December 1986	–	Mr Wallace was released from Lewes Prison on parole.
9 October 1996	–	Mr Wallace's conviction was quashed after the case was referred to the Court of Appeal (Criminal Division) by the Home Secretary, (the second appeal).[337]

459 Following Mr Wallace's arrest his house was searched by Sussex Police, and two notebooks were seized. These were later passed to the SIS.[338] One contained lists of individuals, most of whom were alleged to be members of Loyalist or Republican terrorist organisations, or organisations and publications which were believed to be sympathetic to such terrorist organisations. This volume can be described as containing information of a miscellaneous nature related to terrorist activity in Northern Ireland. The other volume contains miscellaneous entries relating to intelligence and political matters in both the United Kingdom and other countries. Many of the entries relate to notorious episodes of international terrorism at the time, such as the hijacking of an EL AL flight from Zurich to Tel Aviv in February 1969. While most of the notes in the second volume relate to matters predating Mr Wallace's departure from Northern Ireland, there are later entries, such as one relating to events in 1976.[339] The only significance of both documents and the information contained therein is that they show that Mr Wallace

337 KIN 122058-122070.
338 KIN 3515.
339 KIN 190114.

had long been in the habit of recording information in relation to political and security matters in which he had an interest. There is no reference to Kincora in either of these volumes.

460 The SIS officer who reviewed the notebooks commented that during the six years since Mr Wallace left his position with the AIS he had:

> "…demonstrated that he is mindful of the provisions of the [Official Secrets Act] and has not in fact publicised his knowledge of the Army's intelligence activities in Northern Ireland in the way that we feared he might."[340]

However, that comment has to be read in the light of what Mr Wallace says were his efforts during those years to interest Airey Neave MP and others in Clockwork Orange.

461 At some point while he was in prison Mr Wallace produced the extremely detailed 16-page document, parts of which we have already referred to, with the following title,

> "Political and security implications regarding the disclosure of security classified information to assist in the investigation of the allegations relating to the Kincora Boys' Hostel, Belfast".[341]

Despite the reference to "the investigation of the allegations relating to the Kincora Boys' Hostel, Belfast", a great deal of this document is devoted not to Kincora but to a very detailed statement of Mr Wallace's grievances about the events leading up to his arrest and dismissal, the CSAB hearing and Clockwork Orange 2. He described in considerable detail the nature of the work that he did in Northern Ireland, and we have already quoted from, and examined, parts of this document already when we considered Mr Wallace's account of how he was contacted by a social worker about her concerns relating to Kincora, and how he leaked Kincora information to journalists which no one used.

462 We consider it noteworthy that nowhere in this exceptionally detailed document dated March 1982, in which he developed in considerable detail how he came by the knowledge he claims to have had as early as 1972, did he make any reference to the existence of the 8 November 1974 document.

340 KIN 3514.
341 KIN 102798.

463 This was not the only opportunity Mr Wallace had about that time to disclose to others the existence of the 8 November 1974 document when he was informing newspapers and others about what he knew of the sexual abuse of children at Kincora and in Northern Ireland. On 22 March 1982 the *News of the World* carried an article about Mr Wallace by Iain Macaskill.

> "A convicted killer holds the key to a growing sex scandal involving top members of the Establishment.
>
> Colin Wallace, serving 10 years for manslaughter, is threatening to expose the guilty men. He says he knows the names of MPs, Lawyers, Civil Servants, Councillors and policemen involved."[342]

464 Later in the article under "Secret Papers" appears the following.

> "He [Mr Wallace] wants guarantees that he will be able to give a full account of what happened, the people involved, and refer to secret papers.
>
> Then he says, he is prepared to 'blow the lid' off the whole Kincora affair.
>
> Wallace has told friends that he saw the list at Army HQ in Lisburn. The names were on three foolscap sheets.
>
> The file is said to be made up of ten portraits of people involved and details of the roles they played.
>
> The list includes names of MPs who have visited Ulster before the scandal was first exposed two years ago.
>
> Senior Civil Servants seconded from London to Belfast are also named, plus local politicians who used the vice ring, or knew about it and took part in the cover-up".[343]

465 The "list" to which the article referred was described in the article in this passage.

> "Wallace has told friends of a secret list of 60 men in the homosexual vice ring centred on Kincora House, a school for deprived children in Belfast".[344]

342 KIN 50159.
343 KIN 50159.
344 KIN 30234.

466 This was not the only reference by Mr Wallace to seeing such a list. On 4 March 1984 Mr Wallace was reported as saying in the *Sunday World* that he saw a three-page hand written document containing the names of many individuals involved in a paedophile ring in Northern Ireland.[345] This appears to be a reference to the list which Mr Wallace was reported to have seen containing 60 names according to the *News of the World* report. The Inquiry asked Mr Wallace to (a) say who showed the document to him, where and when, (b) the circumstances in which he saw the document and (c) to "give any of the names on the document that he can remember."[346] Mr Wallace has ignored this request.

467 As we see below, Mr Wallace admitted to the police in 1982 that he had seen Mr Macaskill, yet in his letter to the Inquiry of 17 October 2016 he implied that he had not done so. Mr Wallace referred to a report in the *News of the World* of 21 February 1982 and said,

> "…I assume that [the reporter] was probably given the information verbally by someone who had access to my disciplinary hearing procedure. I was in Wormwood Scrubs prison in February 1982 and had no contact with the press".[347]

468 We can conceive of no proper reason why Mr Wallace is not prepared to provide this Inquiry or the police with whatever information he can provide about the names that appear on that list. As the many documents to which we have referred amply illustrate, Mr Wallace has recounted over the years in great detail the names and functions of many of those in relation to whom he says he worked or in respect of whom he has made allegations. It is the duty of anyone who holds information that may lead to the identification and apprehension of those who are believed to have committed serious crimes, such as the sexual abuse of children, no matter how long ago that may have occurred to inform the police so that the police can investigate to see whether the alleged offenders are still alive, and if they are alive to question them.

469 If Mr Wallace has that information he should have provided it to the police, and he should provide it now. If he does not provide it, we can only consider that his reason for not doing so is because he did not have and does not have the information. Mr Wallace has not provided this

345 KIN 112363.
346 KIN 123328.
347 KIN 124810.

Inquiry with any of this information. We can see no reason whatever for his failure to do so if this information is, or ever was, within his possession.

470 On 29 April 1982 Mr Macaskill gave D/Insp Mack and D/S Elliott of the RUC two documents which they marked SRM 9 and SRM 9A. Mr Macaskill said he had received these through the post, and he could only assume they came from Mr Wallace. He told the police that he had not used any of the contents of either in any publications as he was not satisfied of the truthfulness of their content.[348] SRM 9 can be found at KIN 30235 – 30268. It included the grounds of Mr Wallace's appeal against conviction in a document which appears to have been signed by his counsel. It also included a hand written 27-page document setting out grounds for appeal. This appears to be in Mr Wallace's handwriting; it is not relevant to Kincora and we only mention it for the sake of completeness.

471 SRM 9A is to be found at KIN 30270 – 30271 and appears to be in Mr Wallace's handwriting, and consists of three parts, two of which relate to matters connected with his trial and conviction. An easier to read transcription can be found at KIN 30273 – 30276. Part one of this document is headed "Background information". The following passage relates to Kincora.

> "First reported the Kincora vice ring in the early 70's but no action was taken. In 1974 he complained to senior officers that a cover-up of the Kincora ring was preventing the killers of 10 year old Brian McDermott from being apprehended. Named three people thought to be linked with the vice ring who were suspected of the killing. Later an intelligence organisation planned to discredit a number of Ulster Politicians by falsely implicating them in the ring – Wallace refused to take part. He discussed Kincora with a number of journalists in 1974 and was suddenly posted out of Ulster, accused of being pro-RUC and of giving information to the press without authority. It is believed that a number of senior MP's at Westminster – including several cabinet ministers – were involved in the cover-up."[349]

The reference to having named three people thought to be linked with the vice-ring who were suspected of the killing of Brian McDermott is a matter we consider later.

348 KIN 30093.
349 KIN 30273.

472 On 25 March 1982 Mr Wallace was interviewed at Wormwood Scrubs Prison by D/Supt Caskey and D/S Elliott. During the interview he was asked about the *News of the World* article.

"Q If journalists were writing in the past 2 months speculating that you have information about MP, lawyers, policemen – this could not have come directly from you?

A It could not have come from me. You're referring to the News of the World. It is highly inaccurate to say the least.

Q Have you met the reporter?

A I've met the reporter.

Q What are the inaccuracies?

A I won't say there is a secret list of 60. I couldn't confirm or deny or could I give any idea of the figure.

Q If there were other children at risk in Northern Ireland and if we don't have the information to assist the investigation, do you not think it would be helpful to us if you supplied information. Are there any children at risk?

A I couldn't say that. My knowledge stopped in 1974. I support the current investigation. The difficulties I face are greater at the moment but I can't judge the wider aspect.

Q Would you say there is still a danger?

A I can't say. My direct knowledge ended in 74.

Q Your direct knowledge?

A I don't wish to answer that."[350]

473 Later in the interview the police returned to the question of Mr Wallace's knowledge about the sexual abuse of children in Kincora.

"Q You have no knowledge then of boys in care of the Health Authorities that are exposed to moral danger?

A That's true. My direct knowledge stopped in January 1975.

Q Did it apply to Kincora?

A It's wider than that. There are other children's homes.

Q Can you locate the other homes?

A I wouldn't answer that.

350 KIN 30096.

Q Does it involve military?

A I wouldn't answer that.

Q A Portadown Home?

A No.

Q Lurgan?

A I wouldn't answer that.

Q If I said Clive Fleury you wouldn't say no?

A I wouldn't answer that.

Q Do you know him?

A I wouldn't answer that.

Q If I said you knew him would it make a difference?

A Yes.

Q Is it wider than Clive Fleury?

A I wouldn't wish to get drawn into that. If I say it does or doesn't it would give an indication to my knowledge."[351]

474 On 28 May 1982 Mr Wallace was again questioned by RUC officers, on this occasion by D/I Mack and D/S Elliott. The witness statement of D/S Elliott setting out the Question and Answer exchanges can be found at KIN 30102 to 30114. A number of different issues were discussed during the interview, but the following extracts from the Questions and Answers are relevant to any consideration of what Mr Wallace knew, or did not know, about the alleged list of people referred to in the newspaper articles to which we earlier referred.

"Q Six people have been convicted, does your evidence cover matters outside them. Are there people other than those six who, in your opinion, should be convicted purely for homosexual offences?

A No I'm not sure.

Q Would your evidence then purely relate to the cover-up aspect.

A No I don't think that would be true. I looked at it from a security side and for that reason it obviously lead [sic] into various other fields, my evidence would not be aimed at homosexuality but the background to it and such lead [sic] me to be able to get more precise details.

351 KIN 30100.

Q Do you believe that your evidence would assist us?

A If I were doing the investigation I would like the information, we're shadow boxing so I don't know whether you already have my information. Your investigation, unlike Sir George Terrys [sic], seems to relate to the mechanics whereas Sir George is dealing with the cover-up.

Q No that's wrong, our investigation covers all aspects.

A I think I can say that on the basis of my evidence the RUC don't have anything to worry about.

Q You are saying that you were aware of the goings on in Kincora back in 1974.

A Yes.

Q In Lisburn you would have had information relative to the Rev Ian Paisley and people like that?

A Yes.

Q McGrath?

A Oh yes.

Q Were you aware that McGrath was homosexual?

A Oh yes, our interests would be the personalities of paramilitaries and their personality discrepancies. For obvious reasons we related to the Loyalist side in 74 with the UWC strike.

Q Did you ever speak to or receive any complaint from a Kincora boy?

A I wouldn't answer that, I certainly didn't interview them.

Q Relating to the document we have, are you prepared to answer any questions in relation to its contents?

A No.

Q Is there anything we can do for you?

A I'm stuck in the middle. I would like to help but I'm looking at my own problems first. If this had blown up after my parole it would be alright, I would be able to look after myself, my wife. I'm certainly worried about my case, the 2 stumbling blocks, the Official Secrets Act and the Legal Aid. You know I wanted something done about Kincora in 74. It upset me that things were going on.

Q Why did you not act then?

A I wasn't in a position but I can tell you it really upset me.

Q Do we take it from that that you were aware of the assaults on boys?

A You can take it that I was very upset that nothing was done.

Q You could have done something then and you didn't?

A It still upset me, knowing that I was aware.

Wallace indicated that he was reluctant to answer any further questions on this line and the interview was then terminated."[352]

475 During these interviews Mr Wallace made it clear that he was concerned about a number of matters, some of which were referred to in the previous quotation, such as the availability of legal aid and whether any information he might disclose would thereby put him at risk under the Official Secrets Act. Over the succeeding months the question of immunity for Mr Wallace under the Official Secrets Act was debated in interviews by the police with Mr Wallace and with his solicitor. On 10 July 1982 the Director of Public Prosecutions in Northern Ireland gave the following undertaking to the Chief Constable of the RUC.

> "I am writing to inform you that there will be no prosecution of John Colin Wallace for any breach by him of the Official Secrets Acts 1911-1939 in respect of any communication by him to a member or members of the Royal Ulster Constabulary, of information relating to homosexual offences in Northern Ireland.
>
> Mr Wallace may be so informed. When he is interviewed you will doubtless wish to arrange that it should be made clear to Mr Wallace that it is important that he should make full disclosure of all information which he has concerning the commission of homosexual offences in Northern Ireland at any time, and that in doing so he will not be liable to prosecution for breach of the Official Secrets Acts, irrespective of the source of his information."[353]

476 On 27 July 1982 D/Supt Caskey again interviewed Mr Wallace and read the DPP's undertaking to him. Mr Wallace made it clear that he did not consider that sufficient, and that he also required the consent of the Ministry of Defence.

352 KIN 30112–30114.
353 KIN 30370.

"I have made this clear before. On previous visits I made it clear that clearance should come from Sir Frank Cooper [sic]. The copy of the Official Secrets Act, which I signed, made it quite clear that I must have the written consent of the MoD before I disclose any information.

Q You are not satisfied by the immunity granted by the DPP in Northern Ireland?

A Certainly not – in the wording conveyed during this meeting.

Q If you were to get written clearance from the MoD, are you prepared to disclose all information in your possession in relation to Kincora and other matters?

A Yes, subject to other conditions being met –

1. Firstly the legal aid situation. I would have to prepare a lengthily statement which would have to be vetted by legal representatives.
2. Because of my current circumstances I do not have the opportunity to carry out research. This would have to be done by my solicitor.
3. There is also the problem of documents and material needed by me being seen by third parties, eg prison staff, because of vetting procedures, during the production of the statements.
4. There would be a lengthy time involved, maybe 3-4 months.
5. I am unhappy about various aspects of my own case. I state again that I did not commit the offence for which I was convicted. There are, in my opinion, various matters which may be linked to various aspects of the Kincora investigation and I would therefore wish that these matters and all the evidence relating to my case be examined in the light of the information which I will supply about Kincora."[354]

477 On 25 October 1982 the Director of Security (Army) Major General Garrett, wrote the following letter to Mr Wallace.

"Under the terms of the Official Secrets Act Declaration, which you signed when you resigned your appointment with the Ministry of Defence, you undertook to seek authorisation from this Department before discussing with anyone information gained in the course of

354 KIN 30119–30120.

your employment. It is now necessary for the police to investigate fully allegations of criminal offences involving homosexual conduct in or connected with the Kincora Boys' Home in Belfast. The purpose of this letter is to confirm that you may disclose to Superintendent C. Gaskey [sic] and Inspector S E Cooke of the Royal Ulster Constabulary the information that is in your possession which is directly relevant to the investigation – including, where necessary, information which you gained in the course of your employment with the MoD and which is security-classified. You will, of course, appreciate that your responsibilities for safeguarding information not related to the police investigation remain unchanged and you must therefore be careful not to divulge any information other than that which is directly relevant to them."[355]

478 On 11 November 1982 D/Supt Caskey again interviewed Mr Wallace in the presence of his solicitor at Lewes Prison, and gave Mr Wallace this letter from Major General Garrett. The following exchange took place.

"Q At an earlier interview you stated that you were bound by the Official Secrets Act and you considered if called upon to give evidence you would need legal clearance to disclose the information you have. You have now been served with a document giving you immunity by the Director of Public Prosecutions (Northern Ireland) and also with the document giving you the clearance you suggested you required before you could release this information. I suggest to you that the authorities have been more than reasonable with you in meeting your demands and your concern in relation to the Official Secrets Act and I, as the police officer in charge of the investigation, can see no bar in you divulging the information you allege you possess.

A I have now made it clear to you or your representatives on four consecutive visits that owing to the legal complexities of this matter that I would require adequate legal advice relating to the disclosure of any information and on the alleged immunity which might be provided. The refusal by the authorities to allow me to have that advice leads me to believe that they do not wish all the information relating to this matter to be disclosed. I hope I have made my position very clear to you on each of these interviews with particular regard to the complexity of the information.

355 KIN 30373.

Having regard to the totally negative attitude of the authorities in this matter, I do not think that I can be of any further help to you until I am properly advised.

Q Now that you have been given the clearance you sought from the Ministry of Defence I put it to you that you are in the same position as any other citizen in relation to the law to divulge any information you possess regarding any criminal offence i.e. concerning Kincora in this instance.

A As a matter of fact your statement is incorrect. The wording of the alleged clearance given by the Director of Army Security is not the wording of the clearance which I specifically requested from you on at least 2 occasions and on the face of it, it is not only insufficient but ambiguous. I think its fruitless going on any further with this interview."[356]

479 D/Supt Caskey then started to ask Mr Wallace a further question, which he was not able to complete because Mr Wallace's solicitor advised him not to continue with the interview and both then left the room. That question was intended to ask where Mr Wallace had got his information from and where it was to be found.[357]

480 In his report to the DPP D/Supt Caskey gave the opinion that the investigating officers believed that when Mr Wallace was informed of the nature of the immunity and the undertaking he realised that the RUC had called his bluff and cut the interview short.[358]

481 We are satisfied that on several occasions over many months throughout 1982 Mr Wallace was given every opportunity to provide the police with whatever information he claimed to have that may have enabled the police to investigate other instances where boys may have been sexually abused. Despite being given what we consider to be ample assurances that he was free to do so in the form of the undertaking given by the DPP and the permission given by Major General Garrett, Mr Wallace was not prepared to disclose the names of other homes where he thought children had been abused, or any information relating to assertions he was justifiably believed to have made about a list of names and details of individuals who had been involved in such sexual

356 KIN 30127-30128.
357 KIN 30129.
358 KIN 30026.

abuse. We consider that, at the very latest, by the conclusion of the interview on 11 November 1982 there was no remaining reason why he could not provide the police with whatever information he had relating to the sexual abuse of children in Kincora or elsewhere. His refusal to perform that duty is a matter we have taken into account in assessing the credibility of Mr Wallace and the accounts he has provided both to this Inquiry and over the years about his purported knowledge of events at Kincora.

PART THIRTEEN

The importance of the 8 November 1974/GC80 document

482 We now turn to the memorandum relating to Kincora which Mr Wallace says he wrote on 8 November 1974, and which we have so far referred to as "the 8 November 1974 document". This document first came to light in November 1984, and became the subject of the Caskey Phase Four investigation, where it was referred to by the RUC exhibit number GC80. The witness statements taken by the police during the Caskey Phase Four investigation, as well as references to this document in other papers, referred to the document as GC80, and we will therefore refer to it as "the 8 November 1974 document" or as "GC80", or both as the context requires.

483 As will become apparent, the version labelled GC80 differs in some respects from other published versions of the 8 November 1974 document. The exhibit GC80 is reproduced in facsimile form in Appendix 2 of this chapter. It can also be found at KIN 35081 to KIN 35084. From that version it can be seen that there are hand written comments added to the type written text, some of which appear to have been written by Mr Holroyd, notably the comments appearing on page four of the document beside Mr Wallace's signature. Other comments appear to be in Mr Wallace's writing. When we refer to the 8 November 1974 document as GC80 it is to this version.

484 The importance of the 8 November 1974 document/GC80 when considering the accounts given by Mr Wallace over the years cannot be overstated. GC80 is not just an important element in the accounts given by Mr Wallace, it is at the very centre of those accounts, and is fundamental to the credibility of the allegations made by Mr Wallace about Kincora. The authenticity of the 8 November 1974/GC80 document was called into question as long ago as 1985. ACC Mellor succinctly described the significance of the document when sending the Caskey Phase Four Report to the DPP on 4 September 1985.

> "This file is the end product of an investigation which was commenced as the result of Frederick John Holroyd handing numerous documents to the Essex Police in November 1984. In the main these documents relate to grievances harboured by Holroyd in respect of his resignation from the Army and by Wallace in respect of his conviction on a charge of manslaughter.

However, amongst the documents is one (GC80) dated 8 November 1974 under the signature of Wallace which, if authentic, would indicate that both the RUC and the Army knew of homosexual activity in the Kincora Boys' Home and of homosexual and other illegal activities by persons named in the document well before the Kincora Investigation commenced in 1980. There is, however, nothing in GC80 or the other documents of a potentially criminal nature which has not already been investigated and reported to the Director of Public Prosecution.

If the information in GC80 had been known to the RUC and the Army prior to the date on the document and had this information been deliberately suppressed then both could be severely criticised for not taking the appropriate action to ensure that the allegations were fully investigated.

There is, however, doubt as to the authenticity of document GC80 both from forensic examination and also because those who might be expected to know of its existence or content have denied knowledge of it and in some cases cast doubt on its format."[359]

485 The significance of GC80 can be illustrated by the following parts of the document. The document is headed

"'TARA' REPORTS REGARDING CRIMINAL OFFENCES ASSOCIATED WITH THE HOMOSEXUAL COMMUNITY IN BELFAST.

Reference A: Attached RUC background paper on 'Tara'

Reference B: Attached RUC report on the death of BRIAN McDERMOTT.

Reference C: Your request for a press investigation into the matters referred to above."[360]

486 On the same page paragraph four explains the relevance of Reference A in the following way.

"Reference A deals with McGRATH'S background in considerable detail but it is inaccurate in a number of respects. The Kincora Hostel in Newtownards Road where he works was opened in 1959 under the control and administration of Belfast Corporation Welfare Department. He does not, as the paper claims, "run the hostel" – he is employed as a 'housefather'. The Warden of Kincora is JOSEPH MAINS and the Deputy Warden is RAYMOND SEMPLE. MAINS was

359 KIN 35005.
360 KIN 35081.

> appointed in 1959 and SEMPLE in 1964. Both men are known homosexuals. Indeed, various allegations of homosexual assaults on inmates of the hostel were investigated by senior Welfare Department staff in 1967 but no action was taken against anyone. (see notes of a report by Mr H. MASON at flag 'N')"[361]

487 On the fourth page of the document under the heading "Conclusions and Recommendations" there appears the following paragraph.

> "On the other hand, if the allegations are true then we should do everything possible to ensure that the situation is not allowed to continue. The youngsters in these hostels almost certainly come from problem families, and it is clear that no one will fight their case unless we do. Those responsible for the murder of BRIAN McDERMOTT must be brought to trial before another child is killed, and if it can be proved that there is a connection with this homosexual group, then the RUC must be forced to take action irrespective of who is involved."[362]

The circumstances surrounding the emergence of GC80

488 Before considering the contents of GC80 it is necessary to say something about the way in which GC80 emerged, as well as the physical nature of the GC80 version. When GC80 was given to the police it came in the form of a photocopy of a document which had been typed from an earlier version. It therefore appears to be the case that the photocopy of GC80 is not in fact a photocopy of what was the original version of this document, but a photocopy of a later version.

489 On 7 August 1984 ex-Capt Frederick Holroyd contacted Essex Police and arrangements were made for a meeting with him at Westcliffe Police Station. At the police station Mr Holroyd produced a Photostat, that is a photocopied copy, of GC80.[363] Detective Constable Roberts of Essex Police later told DI Cooke of the RUC that Mr Holroyd told him that GC80 had been retyped from the original and then photocopied, and that various things had been crossed out by Mr Holroyd to protect the sources.[364] In his Inquiry letter of 9 September 2016 and the submission attached thereto, Mr Wallace said that the suggestion that Mr Holroyd might have retyped this document was totally untrue.[365]

361 KIN 35081.
362 KIN 35084.
363 KIN 51074.
364 KIN 51028.
365 KIN 124637.

490 Whether GC80 is a photocopy of the version of the 8 November 1974 document is relevant to its authenticity, and the Inquiry therefore asked Mr Wallace to produce "all original versions (and not photocopies) of the memorandum – whether draft or final, for inspection by the Inquiry".[366] Mr Wallace has not done so.

491 In *Who Framed Colin Wallace?* it is said that forensic tests by *The Irish Times* "were inconclusive because the document had been photocopied".[367]

492 On 23 June 2016 Mr Holroyd wrote to the Inquiry and attached 12 pages of material which the Inquiry is satisfied were either written by, or in conjunction with, Mr Wallace. That letter refers to GC80 and stated that,

> "Paul Foot submitted a copy of the document to two of the UK's foremost document experts independently. Both experts concluded that there was no evidence that more than one typewriter and one typist had been involved in the production of the document".[368]

493 The Inquiry asked Mr Wallace to provide copies of any such reports,[369] but he has not done so.

494 In the document sent with Mr Holroyd's letter of 23 June 2016 there is a reference to Mr Wallace's hand written notes on Clockwork Orange being submitted to Dr Julius Grant, and to Dr Grant's conclusion,

> "That the documents were consistent with being written in the mid-1970's".[370]

There are references in *Who Framed Colin Wallace?* to Dr Grant's examination of the Clockwork Orange notes at pages 42 and 43, 357 and 358, and 379. The references in *Who Framed Colin Wallace?* to the reports of Dr Grant on the hand written Clockwork Orange notes contrast with the absence of any reference to forensic tests on GC80 being carried out other than by the *Irish Times*.

495 We consider it surprising that Mr Foot made no reference to forensic tests on GC80 being carried out at his request, when the only reference to such tests on GC80 is to the inconclusive reports apparently obtained

366 KIN 123327.
367 Page 144 of the book, KIN 5205.
368 KIN 124601.
369 KIN 123327.
370 KIN 124603.

by *The Irish Times*. If such reports had been obtained by Mr Foot, we consider it highly likely that Mr Wallace would have copies, yet he has ignored the Inquiry's request to produce copies of any forensic reports that he may have on GC80. We considered his failure to do so, despite his assertions that such reports exist, was relevant when considering the authenticity of GC80 and the credibility of Mr Wallace's accounts.

496 The reference to more than one typewriter and one typist being involved in the creation of the physical document which purports to be GC80, that is in the creation of the first version that physically came into existence, echoes comments that Mr Wallace used two typewriters in his work at HQNI. In May 1985 when he was shown GC80, Mr Broderick said that

> "Wallace used two different typewriters, one was kept by Wallace for his un-attributable information leaked to press".[371]

If Mr Broderick's recollection was correct, that shows that when Mr Wallace was creating false documents as part of his work at HQNI he was alert to the risk that unattributable information could be traced back to the Army if he were to use his Army issue typewriter.

497 GC80 was examined at the Northern Ireland Forensic Laboratory in 1985 as part of the Caskey Phase Four investigation. At that time Donald Budd specialised in examining documents whose authenticity was in question. In his report of 14 February 1985 he pointed to the possibility that the first page of GC80 had been interfered with, giving three reasons.

1 A horizontal line on the first page "could indicate the addition of a piece of paper to the top of this document, possible to cover other information, at the time of photocopying."

2 Differences in "the shape of the tail of the number "9" in the date of 8 November 1974 from that of 9s in the remainder of this document would appear to lend some weight to this possibility".

3 The absence of "CONFIDENTIAL" from the bottom of page 1 of document 1 [GC80] yet present though obliterated at the top and bottom of the remaining 3 pages of this document, could be further evidence of interference to page 1."[372]

371 KIN 190029.
372 KIN 35048.

498 Mr Budd's comments are cautiously expressed, and at their height the indications that GC80 had been "interfered with" are only described as "possibilities". While we do not discount Mr Budd's comments, we regard them as providing limited positive assistance in determining when GC80 was created.

The format of GC80

499 A number of military witnesses who where in HQNI in 1974, and who might be thought to be able to throw some light on the authenticity of GC80, were interviewed during the Caskey Phase Four investigation. One of those interviewed was Roy Pace, who as Warrant Officer Pace was the Chief Clerk of Public Relations Branch HQNI between June 1973 and June 1975. One of his main tasks was to maintain the Classified Documents Register, and he said that:

> "Every classified document, draft or otherwise, on receipt at my office would have been entered in the Classified Documents' Register, stamped and given a serial number. The movement of the draft classified document would have been recorded as would its destruction. I see no such stamp on this document, neither does the document have a reference number which it would have been given had it come through my office. Generally this document is incorrectly laid out and would never have been accepted by a military office. I can state that this draft would never have been presented to a senior military officer in its present form. The style of writing is as far as I can recall similar to that of Colin Wallace."[373]

500 Mr Pace pointed to a number of other differences between the layout of GC80 and what he would have expected in a military document, differences that he regarded as significant. In particular he would have expected to see all the "flagged" documents. Whilst some of these points may seem arcane and pedantic, nevertheless the overall appearance of the layout of GC80 does not conform to the rigidly formulaic structure and layout of the very large number of Army reports and memoranda examined by the Inquiry. Mr Pace said,

> "At the time that this document was apparently written, the Public Relations Branch had become part of Army Information Services. I have examined this document and do not recall ever having seen the document before. Neither do I recall any decision on the content

373 KIN 35064.

> of the document. If such a document had existed at the time in question and had been passed to me I would have read it to establish the correctness of the service writing layout and in this I would have referred it back to the author for the following reason."[374]

He then went on to refer to a number of specific points where the document departed from the format he would have expected in a military document.

501 A number of other military personnel stationed at HQNI in 1974, and who might also have been expected to have been aware of, or to have seen GC80 were interviewed. Each said that they had never seen the document, or had no recollection of doing so, and had no recollection of any discussions of homosexuality. These were

1 Elizabeth Yarr, a personal secretary who worked in the Public Relations Branch.[375]

2 Major I, who worked at the Army Press Desk.[376]

3 Lt Col Peck, who was a General Staff Officer One (GSO1) until July 1974.[377]

502 His successor was Lt Col Railton who was in the Army Information Branch at HQNI from June 1974 until October 1975, and the person to whom GC80 was addressed. He was shown GC80 in July 1985 and responded as follows.

> "I have been shown a document marked GC80 which is dated 8 November 1974. I have had an opportunity to read over this document and examine it and I would say that the context in which this document appears to have been compiled does not ring true. I note that the document is addressed to me in manuscript. I can state that I do not recall having seen this document before and can categorically state that I had no knowledge of homosexual activities at Kincora Boys' Home or any knowledge of the McDermot [sic] murder other than that which appeared in the Press at the time. Had I been aware of the subject matter of GC80 I would have brought this to the attention of the appropriate authorities."[378]

503 Brigadier F was the Col GS (Intelligence) at HQNI and responsible for handling all intelligence on behalf of the GOCNI. When he was shown

374 KIN 35063.
375 KIN 35065.
376 KIN 35061 and 35062.
377 KIN 35056.
378 KIN 35049.

GC80 he said that he had never seen it before, nor had he seen any draft of it. He commented that it "is produced in the style of the alleged author John Colin Wallace". He went on to say:

> "Wallace was a very experienced and clever Press Relations Officer and produced material for media as well as counter propaganda. Wallace at any time would not have been given access to intelligence papers or papers held in the intelligence community at HQNI. In the production of this document GC80 Wallace is stating that he had access to intelligence papers from the RUC. I would state that any such documents would have come through me as Head of Intelligence and would not have gone to the Information Policy Department where Wallace was employed. If this was a genuine document and had been produced at the time it would have been brought personally to the Head of the Intelligence Department who would have had the document researched and vetted. On no account would Wallace have been given access to intelligence documents. In relation to the content of GC80 I do recall the organisation TARA but do not recall any details. I do not recall any complaints or allegations of homosexuality in Boys' Homes in N Ireland."[379]

504 In 1985 Major General H Garrett was the Director of Security (Army) at the MoD, but from November 1972 until January 1975 he was a Brigadier who was Chief of Staff at HQNI responsible for all staff including Intelligence. In 1985 he explained that in his time at HQNI the normal practice was that the majority of intelligence was briefed directly by the Col GSO Int to the Commander Land Forces (CLF). When Major General Garrett was shown GC80 he said this in his police statement of 16 July 1985.

> "I have not seen this document before and I was not aware of the content of the document during my period in N Ireland. I knew the alleged author of this document, John Colin Wallace, during my tour in N Ireland and would state that had Wallace been in possession of this information at the time he would have brought this to me at any time as he was considered part of the team and as such had easy access to me. It would have been more likely that he would have discussed this with his immediate supervisors and if he had not got satisfaction at that level would then have felt he could come to me. I do not recollect any such information being brought to my notice by Wallace or anyone else."[380]

379 KIN 35054 and 35055.
380 KIN 35053.

PART FOURTEEN

General Sir Peter Leng

505 General Sir Peter Leng died in 2009. From January 1973 until March 1975 as a Major General he was the Commander Land Forces in Northern Ireland, and as such the second in command to the GOCNI, who was Lieutenant General Sir Frank King. Mr Wallace has asserted on many occasions that in May 1974 Major General Leng was aware of the allegation about Kincora, although that allegation was not contained in *Who Framed Colin Wallace?*, which was first published in 1989. In the 1990 paperback edition the only reference to Major General Leng is at page 41 in the context of Clockwork Orange.

> "The Army's involvement in Clockwork Orange was approved early in 1974 by the Commander of Land Forces, Northern Ireland, Major General Peter Leng. Colonel Peter Goss, the Senior Army Intelligence Officer, Lisburn, was instructed to release to Colin secret information on terrorists. Captain "Tim Perkins", another Intelligence Officer, was appointed to do the basic research and supply Colin with the results."[381]

506 The account given at page 139 of the reasons for the creation of the 8 November 1974 / GC80 document infers that Mr Wallace composed it solely on his own initiative, and it makes no reference to his being instructed or encouraged to do so, whether by Major General Leng or by anyone else.

> "Colin wondered whether McGrath and his colleagues at Kincora were "held in place" to assist with such secret intelligence initiatives. If so, if the boys at Kincora were being sacrificed to the machinations of Intelligence, the process had gone too far. As with Clockwork Orange, the time had come to call a halt.
>
> On 8 November 1974 Colin wrote a memorandum. He is not clear today (because he only has a copy) for whom the memo was intended, but it would certainly have gone to his superior officer Jeremy Railton, Head of Information Policy, and almost certainly also to Army Intelligence and the Army's RUC Liaison Officer at Police Headquarters in Belfast."[382]

507 However, in letters he wrote to the Prime Minister in 1990, Mr Wallace alleged that Major General Leng did know about the sexual abuse at Kincora, especially in his letter to the Prime Minister of 12 May 1990 in

381 KIN 5153.
382 KIN 5202.

which he referred to an interview given by General Leng to the *Sunday Times* and to extracts from the tape recordings upon which the *Sunday Times* article of 18 February 1990 was said to be based. To the present day, Mr Wallace continues to maintain that General Leng was aware of the abuse at Kincora and he refers to the *Sunday Times* interview and to the recordings in support of his assertions. An example is the following extract from his letter in submission to the Inquiry of 9 September 2016.

> "Moreover, General Leng makes it clear in his recorded interview with the Sunday Times in February 1990 that he was aware in 1973/74 of McGrath, where he worked and the "homosexual insinuations". General Leng also recalls writing a memo pointing out that the sexual abuse allegations were a police matter."[383]

508 After quotations relating to Clockwork Orange, Mr Wallace gives the following quotation from the transcript of the *Sunday Times* interview. The interviewer (the journalist Barrie Penrose) turned to the subject of Kincora.

> "PENROSE: You said in the memo according to [Mike] Taylor that the RUC and the Social Services I think ought to be brought in here because the file named men and boys who were obviously part of this abuse which we all know about since.
>
> LENG: Yes, I recall that,
>
> PENROSE: Do you? And you said take action. They waited because obviously there had been other members suggesting this from Junior Officers, but it was yours that finally convinced Taylor that this was going to happen, but of course it went on for another six or seven years, but again that wasn't your fault. It was just to remind you that there were homosexual abuses taking place, namely by the House Father named McGrath.
>
> LENG: Yes.
>
> PENROSE: who was also the leader of TARA, and of course eventually that was all proven in court some years afterwards, and also a man named McKeague, but I mean this is obviously outside...
>
> LENG: Yes, I do remember the homosexual insinuations and I do remember saying this is a police business, not ours."[384]

383 KIN 124650.
384 KIN 124651.

509 Mr Wallace had this to say about the *Sunday Times* article.

> "The Sunday Times story based on General Leng's recorded interview with Barrie Penrose was published in the first edition of the newspaper on 18 February 1990. I was reliably informed that the MoD put pressure on the Sunday Times to withdraw the story. Indeed, the story was withdrawn from subsequent editions. It is not difficult to understand why the MoD reacted so negatively to the story, because General Leng's comments undermine almost everything the Department and its Ministers had been saying about "Clockwork Orange" and Kincora."[385]

510 As Mr Wallace says, the *Sunday Times* article was withdrawn, but not for the reason he believes. The editor, Andrew Neil, listened to the recording of the interviews and concluded that the story should be withdrawn from all future editions because the recordings did not support the assertion that General Leng had authorised Clockwork Orange. Mr Neil's explanation given shortly afterwards makes it clear that he did not withdraw the story because of pressure from the MoD.

> "[It] has been suggested by several politicians in the House of Commons that, under pressure from the MoD, The Sunday Times pulled the story about the Colin Wallace affair from its first edition last Saturday night. That is untrue. The story was pulled, but there was never any pressure from the MoD or anybody [else to] do so. The facts are as follows.
>
> The Sunday Times first edition contained a page one story "General backs Wallace claims" in which it was said that General Sir Peter Leng, Commander Land Forces in Northern Ireland from 1973 to 1975, confirmed the existence of Clockwork Orange and, further, claimed it had not been authorised by the Northern Ireland Office. After the first edition went to press the MoD issued a statement which said that we had either distorted or misunderstood what the General had said. The General, said the MoD, had confirmed to the Ministry that he had said neither [of] the two statements attributed to him by the Sunday Times.
>
> My reaction was simple: the MoD, realising the import of what the general had told us, had got him to retract his statements as part of a damage limitation exercise. Luckily, I thought, our two telephone conversations with the General had been tape recorded.

385 KIN 124652.

> [I] asked to listen to the recordings so that I could pick the best quotes from [the] General in order to refute the MoD rebuttal. But after listening to the tapes I was forced to conclude that the general had neither confirmed Clockwork Orange nor its official authorisation. I had no choice, therefore, but to withdraw the story from all future editions of the Sunday Times, and issued directions to that effect at 8pm Saturday night. At no stage did the MoD [or] any other official body ask for the story to be withdrawn, or put any pressures, directly or indirectly, on the Sunday Times to do so. The decision [was] taken for purely journalistic reasons, above all for reasons of accuracy."[386]

511 Mr Wallace is therefore incorrect in his belief that the *Sunday Times* withdrew the story because of pressure from the MoD. The Inquiry has obtained a complete copy of the transcript made by the *Sunday Times* which was sent on 22 February 1990 by Mr Neil to Merlyn Rees, who was the Secretary of State for Northern Ireland in the Labour Government formed following the outcome of the General Election held on 28 February 1974.[387] Mr Wallace clearly had a copy of that transcript when he wrote to the Prime Minister on 12 May 1990. In that letter he said,

> "I attach for your information extracts from the tape recordings of the exchanges between General Leng and the Sunday Times. I think you will agree that they show:
>
> 1. Senior Army Officers at HQ Northern Ireland were aware in the mid 1970s of allegations of homosexual abuse at the Kincora Boys' Home.
> 2. That the "Clockwork Orange" project originated at the Northern Ireland Office and involved members of MI5.
> 3. Setting aside the first paragraph of the story which I think is much too strong, the tape recordings do support the Sunday Times account of what the General allegedly said."[388]

512 Mr Wallace has used quotations from the transcript over many years when referring to General Leng and Kincora, and has done so in his submission to this Inquiry. The transcript provided by the *Sunday Times* runs to 27 pages, and is to be found at KIN 124556 and following, see

386 KIN 185010.
387 KIN 124555.
388 KIN 104233 and 104234.

Appendix 3 of this chapter. It includes comments during an interview with Sir Frank King, who was the GOCNI at the time of the events the Inquiry is considering. As can be seen from the transcript both interviews took the form of telephone interviews during which the conversations were tape recorded. When the entire transcript of the questions and answers relating to General Leng are read we are satisfied that Mr Wallace's selective quotations misrepresent what General Leng actually said about Kincora.

"PENROSE: Yes. And Colin Wallace you would have known?

LENG: Well hardly. I mean no and yes, but as he was a captain working right down the chain...

PENROSE: Yes

LENG: I didn't. I mean I hardly came across him at all.

PENROSE: Because everyone, including Broderick, I must say, they speak so highly... and so do the records of him at the time, that he was hard working, and so on, but that's something that obviously... You were at a level where you wouldn't have come across him very much.

LENG: Correct.

PENROSE: But it wouldn't surprise you that he was involved along with Broderick and the others and Taylor...

LENG: If he was working under Broderick he would be involved.

PENROSE: With Clockwork Orange, Yes. And how many people would have known about Clockwork Orange? Would it... I am just wondering...

LENG: Well I think that the senior intelligence officer would have known, Broderick would have known, Mike Garrett."[389]

It is clear that General Leng was saying in 1990 that he had very little direct contact with Mr Wallace.

513 There then followed a number of exchanges about Clockwork Orange during which General Leng made clear that his memory of events more than fifteen years before was not good.

"PENROSE: Right, because there was Clockwork Orange one and two but I am sure your memory doesn't stretch back that far?

389 KIN 124559.

LENG: It doesn't I'm afraid. I've got a terribly bad memory anyhow.

PENROSE: So – I mean – when it was mentioned to you, it was mentioned to you as what?

LENG: Well, I don't want to be quoted, because I can't actually recall, but I think it was, from rough memory, it was because we have to investigate these terrorist organisations and I said "go ahead and investigate".[390]

514 Some pages further on attention turned to Kincora.

"PENROSE: Did you know there was a Clockwork Orange One and Two?

LENG: Really?

PENROSE: ...who was also the leader of TARA, and of course eventually that was all proven in court some years afterwards, and also a man called McKay, but I man [sic] ...

LENG: Yes I do remember the homosexual insinuations and I do remember saying this is a police business not ours.

PENROSE: Yes, because you probably know that since then, the suggestions had been the MI5 or others, not the Army but others, where in fact using, obviously, a blackmail hold on people like McGraph [sic] which he has since confirmed. I mean that is a matter record now, that he was blackmailed into working for intelligence to inform and so on, so you can see the tug of war that was taking place from your side, saying police, Social Services take action, and the other side saying no, we need the information...

LENG: But of course I wasn't part of the other side.

PENROSE: No, quite. Well look, I'll get this in the post..."[391]

515 When considering the entirety of these exchanges it has to be borne in mind that there were many leading and suggestive questions by the interviewer during a telephone interview with someone who was being asked to recall events many years before, apparently without

390 KIN 124558.
391 KIN 124562 and 124563.

time for reflection and who had made it clear his memory was poor. We are satisfied that when one looks at the entirety of these exchanges that although on one construction the words "yes I do remember the homosexual insinuations and I do remember saying this is a police business, not ours" suggests that General Leng did know about the abuse at the time, when the exchanges are considered as a whole the references by General Leng to boys escaping from a remand home clearly refer to St Patrick's Training School and not Kincora. Kincora was not a remand home, and as we have established when examining St Patricks Training School on the Glen Road in West Belfast, there was a serious problem there during the 1970s with boys absconding after they had been remanded by the courts to the training school when charged with terrorist and public order offences. Mr Wallace ignores this reference.

516 After the *Sunday Times* article appeared, General Leng and General King had a meeting with officials from the Ministry of Defence on 17 February 1990. A note of that meeting contains the following reference to what General Leng said about Kincora.

> "7. On Kincora Leng remembered discussing with the Chief of Staff the escapes of youngsters back into violence. Kincora came up in relation to escapes, he said.
>
> 8. Leng was questioned about Tara – "don't remember". MaGrath [sic] – No bells. Homosexual activity at Kincora – "I have a nagging thought about that. Len Garrett may have discussed homosexuality there with me. My recollection is unclear".[392]

517 If this note is an accurate representation of what General Leng said in 1990, his recollection of any question of homosexuality was far from clear and the references to "insinuations" in the *Sunday Times* transcript have to be viewed with that in mind. However, looking at both accounts, it is clear that what General Leng remembered were not discussions about homosexuality at Kincora but discussions about the problems created by boys absconding from St Patricks Training School and not from Kincora.

518 In 1985 General Leng made a statement to the police during the Caskey Phase Four investigation into the 8 November 1974 / GC80 document. In this statement General Leng said that he had never seen the GC80

392 KIN 190035.

document before, nor had he any knowledge of any of the hostels, or of allegations of homosexuality in children's homes in Northern Ireland. He confirmed that he was aware of St Patrick's Training School in its capacity as a remand home, and the concerns of Army Commanders that "young men" on remand for terrorist offences were absconding from St Patrick's.

519 In view of the significance attached to what General Leng has said about Kincora, we set out the relevant portion of his statement below.

> "I was Commander Land Forces N Ireland from Jan 1973 until March 1975. I have closely and carefully examined the document marked GC80 and I can state that I have never seen such a document before. Documents of this nature would have been handled at a lower level and if a problem arose the subject in question would be discussed in my office with either the Chief of Staff, Brigadier Garrett, or for the major part of my tour by [Brigadier F], Col GS Intelligence or in the last three months by Col M. I always insisted on personal briefing rather than having to read a mass of documents. I would not therefore have received a document in draft and usually only handled the most important policy documents in final form. Nor have I any knowledge of this document nor was the information contained in the document under question ever brought to my notice. I certainly cannot recall having heard of any of the hostels named in the document nor was I aware of any allegations of homosexuality in any boys' homes in N Ireland. However, I was aware of the remand home, St Patrick's situated in west Belfast. In 1974 the Army Belfast Commanders were concerned about the number of young men on remand for terrorist charges who were absconding from this home and re-involving themselves in terrorist activities. I was aware of the Protestant organisation Tara but cannot recall at this late stage any of the personalities involved. I do not recall the McDermot [sic] incident."[393]

520 We are satisfied that General Leng's account in his police statement in July 1985 is incompatible with everything that Mr Wallace has alleged about General Leng's knowledge of, and approach to, sexual abuse of children in Kincora in 1974. We are satisfied that General Leng's recollection as he explained it later in 1990 in the *Sunday Times*

393 KIN 35051 and 35052.

interview can be seen from the transcripts, and his subsequent remarks to the Ministry of Defence, as consistent with his position as stated in his July 1985 statement.

521 General Leng's recollection as he set it out in July 1985, more than four years before he referred to the matter during the course of a telephone conversation with the journalist Barrie Penrose, leaves no room for doubt that General Leng was saying then that he knew nothing about Kincora nor had received any information to suggest that children were being abused in Kincora. If General Leng's statement in 1985, and his subsequent remarks, were true, they contradict and do not support Mr Wallace's assertions.

522 From the following extract of his submission to the Inquiry sent with his letter of 9 September 2016 it can be seen that Mr Wallace regards the late General Leng as a person of great integrity, and he argues that General Leng's comments in the *Sunday Times* interview provide powerful support for Mr Wallace's assertions about Mr Wallace's knowledge of sexual abuse in Kincora in 1974.

> "Those who served with General Leng will be well aware that he was a very professional and forthright officer who had great integrity. There is no doubt in my mind that his knowledge of McGrath and Kincora as expressed above would have been communicated very clearly and forcibly to those around him. I am amazed that the Inquiry transcripts indicate that the Inquiry made no determined attempt to challenge senior military and Intelligence witnesses over General Leng's comments. I am also disgusted that those officers and officials, including the senior Information Policy Officers, did not have the courage to speak out and confirm what General Leng had said.
>
> I believe the Inquiry must face up to this issue because General Leng's comments go to the very heart of the Inquiry's investigation into Kincora. The Inquiry must decide: do they believe General Leng, who had no reason whatsoever to lie, or do they believe MoD and Intelligence witnesses who had very good reasons to lie. It is sad and very worrying that CTI [Counsel to the Inquiry] has attempted to play down the significance of what General Leng said. If it had not been for the stance he took on this issue, I would not have been talking to the press in 1974 about McGrath's homosexual activities."[394]

394 KIN 124652.

523 As Mr Wallace concedes, General Leng had no reason to lie. General Leng's recollections in 1985 of Kincora were given significantly closer to the events he was asked about in 1974, and when he had the opportunity to study, and reflect upon, the contents of the 8 November 1974/GC80 document. They are consistent with, and supported by, the accounts of the other witnesses who were interviewed in 1985. We see no reason not to accept General Leng's account contained in his 1985 police statement.

PART FIFTEEN

524 Before we consider the other contents of the 8 November 1974 / GC80 document we should make it clear that we accept Mr Wallace was the author of the document. The issue that was raised as early as the Caskey Phase Four investigation of 1985 is whether the document was composed in November 1974 or at a later date. In this part of this chapter we examine the contents of GC80 to see whether the internal evidence assists in establishing when the document was or was not compiled.

Reference A

525 At the head of the document appears the following.

> "Reference A: Attached RUC background paper on 'Tara'."[395]

The RUC background paper referred to as Reference A is mentioned expressly in the paragraphs numbered 1, 4 and 6, and is identified as the source of much of the information referred to in paragraphs 1-9. No such RUC document has ever been found by the Ministry of Defence, by the RUC, by the PSNI, nor has this Inquiry in its exhaustive examination of files found anything that would answer that description.

526 Paragraph 4 starts,

> "Reference A deals with McGrath's background in considerable detail but it is inaccurate in a number of respects."

The remainder of the paragraph does not say in what respects the RUC "background paper on Tara" was inaccurate, but, as can be seen from paragraphs 4 and 5, the references within the text suggest that Mr Wallace had knowledge of various matters, including the Mason File.

> "4. Reference A deals with MCGRATH's background in considerable detail but it is inaccurate in a number of respects. The Kincora hostel in Newtownards Road where he works was opened in 1959 under the control and administration of Belfast Corporation Welfare Department. He does not, as the paper claims, "run the hostel" – he is employed as a 'housefather'. The Warden of Kincora is JOSEPH MAINS and the Deputy Warden is RAYMOND SEMPLE. MAINS was appointed in 1959 and SEMPLE in 1964. Both men are known

395 KIN 35081.

> homosexuals. Indeed, various allegations of homosexual assaults on inmates of the hostel were investigated by Senior Welfare Department staff in 1967 but no action was taken against anyone. (see notes of a report by Mr H MASON at flag 'N')
>
> 5. It is untrue to say that allegations of assaults on the inmates of Kincora "began shortly after his appointment". As I have pointed out in para 4 above, allegations were made as early as 1967 and there is also evidence that assaults may have taken place as early as 1959, soon after MAINS was appointed."[396]

527 The reference to the "notes of a report by Mr H Mason at flag 'N'" is an unmistakable reference to the Mason File, which we considered in Chapter 27, Mr Wallace has said that he did not keep any of the documents referred to in this document, such as "reference A" or the documents described as being flagged, in this case "flag 'N'".

528 In his submission to the Inquiry sent with his letter of 9 September 2016 Mr Wallace said,

> "I did not retain the various RUC documents referred to in my memo. Neither those documents nor the memo, were designed for release – indeed, I am not convinced that the Army was even meant to see the police documents. In any event, I had no authority to retain them. Also, it is almost certain that I would have re-attached them to the memo when I submitted it to my superiors. The memo by itself would have provided an incomplete picture."[397]

Mr Wallace's explanation that he did not have any authority to retain the documents referred to as flags or References rings somewhat hollow since he clearly did retain a number of documents that he either obtained in the course of his work, or created during the course of his work, such as GC80 itself. If he kept the copy as he claims to have done, it is surprising that given its obvious importance he did not keep copies of the documents referred to in it.

529 The evidence from Mr Bunting of the EHSSB was that he received the Mason File from Mr Mason in 1973, when he took over from Mr Mason upon the reorganisation of health and childcare services and the creation of the Eastern Health and Social Services Board. Mr Bunting explained that he put the Mason File in a drawer in his office and forgot

396 KIN 35081 and 35082.
397 KIN 124665.

about it until he remembered it during the first meeting he had with DC Cullen in March 1976. He explained how DC Cullen then copied the Mason File and returned the original to him. There has never been any suggestion, let alone any evidence to show, that more than one copy of the Mason File had been created in 1971, nor that the RUC ever possessed a copy of the Mason File before 1976, nor that the RUC was aware of its existence before 1976.

530 The reference to both Mains and Semple being "known homosexuals", and by inference from the context therefore known to be so in 1974, either from the RUC document or from the Mason File, is significant. As Semple's superior, Mains knew that Semple had sexually interfered with residents at Kincora as we have explained in an earlier chapter. However, there is no evidence to suggest that the RUC, the Belfast Welfare Authority, or the EHSSB as its successor, knew anything about Semple's offences until these were uncovered during the Caskey Phase One investigation which followed the allegations in the *Irish Independent* on 24 January 1980.

531 Paragraph 7 of GC80 contains a further reference to internal investigations by the Belfast Welfare Authority, described as "the Belfast Corporation Welfare Department" in the document. We attach no significance in the difference in terminology.

> "7. MCGRATH was himself the subject of an internal investigation by the Belfast Corporation Welfare Department in 1972/73, following allegations of more homosexual assaults on the inmates of Kincora. One of our own sources confirmed in 1972 that a number of complaints had been received about his behaviour and that, although the complaints had been passed to senior welfare staff and to the RUC, no action had been taken against him. This would appear to be confirmed, to some extent, by Mr Orr (see flag 'R') in 1973. There were, of course, similar allegations relating to other hostels during this period (see Bawnmore, Westwinds, Burnside etc.) and this conflicts with Reference A's assertion that the allegations were confined to Kincora."[398]

532 The references to "one of our own sources" may well be to Mr Wallace's assertion that he was in contact with a social worker in 1972, as we have already considered. The reference to Mr Orr providing some

398 KIN 35082.

confirmation in 1973 requires examination. The reference to "flag 'R'" suggests that flag 'R' was a document of some sort containing references by Mr Orr to the earlier complaints "passed to senior welfare staff and to the RUC". As with the other "flags" no such document has been found.

533 In chapter 27 we examined the way in which complaints made by R 15 in May and September 1974 that McGrath grabbed him by the genitals were dealt with by EHSSB staff, including Mr Ronald Orr. Mr Orr was a Principal Social Worker with the EHSSB at the College Street Office on the Shankill Road. He was interviewed by D/Supt Caskey on 7 August 1985 and shown paragraph 7 of GC80. Mr Orr told D/Supt Caskey that he did not contact any police officer or soldier in relation to social work.[399] Since the only knowledge of allegations relating to McGrath possessed by Mr Orr related to events in 1974, the Inquiry is unaware of any document compiled by Mr Orr in 1973, or which could be said to support the reference in paragraph 7 of GC80 to Mr Orr possessing knowledge of allegations against Mr McGrath before May 1974.

534 Paragraph 7 goes on to refer to "similar allegations relating to other hostels during that period (see Bawnmore, Westwinds, Burnside etc.)". However, as D/Supt Caskey pointed out in the Phase Four Report, the allegations about the Westwinds home in Newtownards were not made to the RUC until 1975; the allegations about Bawnmore were not made to the RUC until 1980, and the allegations about the Burnside Hostel for boys in Craigavon were not made until after 1980.[400] The RUC documents referred to in Reference A could not therefore have existed in 1974.

Reference B

535 The reference to the "Attached RUC report on the death of BRIAN McDERMOTT" needs some explanation. Brian McDermott was a 10 year old boy who left his home in East Belfast just before 1pm on Sunday 2 September 1973 to go to the Ormeau Park beside the River Lagan. The last confirmed sighting of Brian McDermott alive was in the Ormeau Park at about 3.15pm that afternoon. On Saturday 8 September 1973 a report of what was thought to be a body floating in the River Lagan led

399 KIN 35070.
400 KIN 35017.

to the level of the river being artificially lowered so that a search of the river bed could take place. At a different point on the river the search discovered a hessian sack. The sack contained a torso and a severed right hand, all of which had been subjected to severe burning. The left arm, both legs and the head were missing. The remains were those of Brian McDermott. His murder remains unsolved 43 years later, and because of the horrific nature of the crime understandably attracted considerable media attention.

536 Paragraph 9 of GC80 refers to the murder of Brian McDermott.

> "Reference 'B', which deals with the circumstances surrounding the murder of BRIAN McDERMOTT last year puts forward the theory that the killing had both sexual and witchcraft overtones. The only link that can be identified between the murder and the homosexual community is via JOHN McKEAGUE. McKEAGUE's own statements (see flag 'S') raises more questions than they answer. Certainly, his boast that he will not be prosecuted because "he knows too much about some people" merits serious investigation, but I suspect that he will not be prepared to talk until he is released. It is also rather remarkable that no charges have been preferred against him, at least during the past 3-4 years. Our own investigations of instances of alleged witchcraft or other satanic rites in the Province would tend to dismiss the RUC's theory that BRIAN McDERMOTT's murder could be part of these activities. In the past, 'Black Magic' practices etc have been mainly confined to groups operating from Republican areas, with the possible exception of three cases in County Antrim. I think, however, that from a press point of view, we would be very foolish to give any credence to such claims without the most convincing evidence. The forensic reports on the McDERMOTT murder (see flag 'T') would tend to indicate that someone tried to dispose of the body by cutting it into pieces and burning them. It would also appear that when this failed, the pieces were dumped in the river. The insinuation made in the document regarding the boy's disappearance and the proximity of the REV PAISLEY's church is dangerous nonsense."[401]

537 The reference to "flag 'T'", described as the "forensic reports", suggests that Mr Wallace had somehow obtained at least the post mortem report and probably other documents of a forensic nature. No document

401 KIN 35082 and 35083.

answering the description of "flag 'T'" has ever been found in any of the MoD files that have been examined over many years, and examined by this Inquiry, despite repeated searches. Mr Wallace says that he did not keep the documents referred to as being flagged in GC80.

538 Mr Wallace said to the Inquiry that, to the best of his knowledge,

> "The Army possessed no information about the murder of Brian McDermott other than that which was received by the RUC. Initially, we were told that a police suspect was an associate of John McKeague, but that others may also have been involved.[402]
>
> "In 1974 we at British Army HQNI were given information that the RUC believed the original suspect had been protected by influential people and that attempts to prosecute him had been blocked. The Inquiry should ask the RUC for details of their investigation into Brian McDermott's murder to determine what links, if any, the original suspect had with John McKeague and/or Kincora, and if he was protected by influential people. However, as I pointed out to the police in 2008, I had no direct knowledge of the murder."[403]

539 Mr Wallace's reference to 2008 appears to be mistaken, because it was on 18 March 2004 that he made a police statement in which he said,

> "When I was writing about the McDermott case, I linked his death to witchcraft purely because it was an area I was exploring at that time. I had no evidence that witchcraft or any other occult associated with witchcraft was involved. As a result of linking the McDermott case with witchcraft, it followed that anyone associated with witchcraft became a possible suspect for the murder. One such person at that time was a paramilitary leader by the name of John McKeague, who lived and worked near the area that McDermott had gone missing. This was not based on any evidence, it was only a supposition on my part based on intelligence at hand being evaluated and linked. There were a number of issues in the 1970's and into the 1980's concerning the investigation into the abuse of children at the Kincora Boys' Home in Belfast. I had concern that the murderers of McDermott would not be apprehended due to a cover-up in relation to this investigation, however, I had no knowledge that would have linked anyone from the Kincora investigation to the murder of

402 KIN 124671.
403 KIN 124672.

> Brian McDermott. I am not in possession of any information that would link anyone to the McDermott murder. I can confirm that I am not aware of any cover-up concerning the McDermott case."[404]

540 Mr Wallace has not always been as forthright about his lack of knowledge about the McDermott murder as he was in the 2004 statement. In his interview of Mr Wallace, in the presence of Mr Wallace's solicitor, on 27 July 1982 D/Supt Caskey questioned Mr Wallace about his knowledge of the three suspects for the killing of Brian McDermott which were mentioned in the "background notes" document to which we have already referred. This was part of the SRM9A document which Mr Maccaskill of the News of the World received through the post. The portion of that document referring to Brian McDermott's murder was as follows.

> "In 1974 he complained to senior officers that a cover-up of the Kincora ring was preventing the killers of a 10 year old Brian McDermott from being apprehended. Named three people thought to be linked with the vice ring who are suspected of the killing".[405] (emphasis added)

541 We consider that Mr Wallace's response to the questions about his knowledge of the killers of Brian McDermott was revealing.

> "Q: did you see that document SRM9(a)? It is a photocopy. Are you the author of that document?
>
> A: I would not be prepared to make any comment in relation to that document.
>
> Q: I suggest to you that you are the author of that document and that, that is clearly identified by the content?
>
> A: I have already stated that I am not prepared to make any comment in relation to that document.
>
> Q: A serious allegation is made in the document that in 1974 a complaint was made to senior officers that a cover up of the 'Kincora Ring' was preventing the killers of 10 year old Brian McDermott from being apprehended and that 3 people were named who were thought to be linked with the vice ring who were suspected of the killing. Have you any comment to make about this?

404 KIN 123001 and 123002.
405 KIN 30273.

A: As I have said before I have no comment to make about this document.

Q: I put it to you that the Official Secrets Act does not extend protection to any person who has information that would lead to the detection of persons suspected of murder?

The solicitor stated that the Official Secrets Act prohibits disclosures by his client without [consent] of any relevant information in his possession.

A: If this information is so important why don't the military just give permission. It is in the public interest for the MoD to give me the permission.

Q: Do you have information that would lead to the identity of these suspected killers?

A: Again I could not reply to that question.

Q: To your knowledge, are these suspected killers still at large?

A: I cannot make any comment on that.

Q: Would you agree with me that it is a serious matter that if suspected killers are at large that every effort should be made to make them amenable to the law?

A: I could not agree more.

Q: If they are still at large, taking into account the terrorist situation in Northern Ireland, assuming that they are of the 'terrorist type' there is every likelihood of them committing further serious offences.

A: This would apply even if they weren't terrorists. Irrespective of who they were I would like to see them brought to book.

Q: If you would like this then this is the time to disclose their identity?

A: This is the time for the MoD to allow me to disclose this information.

Q: Was there an intelligence organisation within the military in Northern Ireland prepared to discredit a number of Ulster Politicians by publicly implicating them in the Kincora Vice Ring?

A: I could not make any comment on that.

Q: You are not prepared to name the 3 men even though they may be killing today?

A: I can't release any information." [406]

406 KIN 30121–30124.

542 We are satisfied Mr Wallace was the author of the SRM9A document, and that he claimed that he knew the names of the three men believed to have committed this appalling murder. We are satisfied that in 1982 he knew that he was caught out in a lie because he knew nothing about the murder of this child, but in order to avoid admitting that he had lied by claiming to have knowledge he did not have, he retreated behind the risible device of saying the Official Secrets Act prevented him from giving information which, if he really possessed it, would have enabled the men to be identified, arrested and questioned.

Reference C

543 The third reference at the head of the document is in the following terms.

> "Reference C: Your request for a press investigation into the matters referred to above".

544 Who made the request is shown in a handwritten note above the typescript.

> "Addressed to; GSO1 (Inf Pol) Jeremy Railton in response to a request from Gen Peter Leng CLF [illegible] M".[407]

It is unclear whose handwriting this is. Col M was living in the USA at the time of the Caskey Phase Four investigation in 1985 and it was decided it was unnecessary to interview him.[408] As we have seen, General Leng and Lt Col Railton both denied that any such request for a report was ever made by General Leng, or that Lt Col Railton ever received GC80 from Mr Wallace.

Reference A and the Bangor prostitution ring

545 Paragraph 10 of GC80 again refers to "Reference A" that is to the RUC background paper on Tara, and at 10(c) states;

> "Various public and political figures who hold positions of power and who are also homosexual protect each other from prosecution. The claims of a prostitution ring involving juveniles and centred on Bangor is not really substantiated, other than by GARLAND's own personal account."[409]

407 KIN 35081.
408 KIN 100192.
409 KIN 35083.

546 The reference to "a prostitution ring involving juveniles and centred on Bangor" is not elaborated in the GC80 document. The only known allegations made to the RUC that might answer this description related to allegations made in articles published in the *Irish Times* on January 12 1982; in a BBC News *Scene Around 6* programme broadcast on 11 February 1982, and in the BBC *Spotlight* programme broadcast on 12 February 1982. *The Irish Times* article claimed that a boy alleged that he was one of a group of boys, some of whom he met while a resident in Kincora, and that some of the boys were regularly escorted by men to hotels in various locations where sexual offences took place. One of these locations was Bangor, Co Down. The boy also alleged that he had been introduced to the men in the "ring" by a close relative. An interview with the unnamed boy was played in the BBC programmes on 11 and 12 February 1982.

547 The *Irish Times* article claimed that the offences dated back to 1972, had been investigated by the police, and the close relative had been prosecuted, convicted and sentenced to a period of imprisonment in 1976. The Caskey Phase Two investigation identified the boy and his identity was confirmed to them by the journalist concerned. We will refer to the boy by the designation given to him by the Hughes Inquiry, R 23. The offences involving R 23 came to the knowledge of the police in 1975 following his visit to Dundonald Police Station when he said he had run away from home. He was taken into care. Subsequently he alleged to Social Services that he had been involved in homosexual relations with his uncle with whom he had been living, and with other males.

548 A lengthy police investigation then followed. R 23 told the police that no more than four men were involved; his uncle, the driver of a mini car he met in Bangor, a man named Robert and a man named Maurice. Robert and Maurice were identified as Northern Ireland barmen. Robert admitted the allegations, Maurice denied them.

549 R 23 denied being a resident of Kincora, or being aware of a homosexual ring involving NIO Officials, policemen, legal figures, business men and boys in care in Kincora.[410]

550 The authors of the Irish Times article were Ed Moloney and Andy Pollak. They told the police that a source they did not wish to name, but who

410 KIN 20063 and 20064.

they called Social Worker C, told Mr Pollak that he had been approached, "probably around late 1975 or early 1976",[411] by a boy who complained that his uncle sexually abused him and took him to hotels in the North Down Area. If any man in the group showed an interest in R 23 then his uncle permitted him to go off with the man for the night.

551 The Caskey Phase Two investigation pursued these allegations in great detail and it is unnecessary for this Report to consider the wider scope and outcome of the investigation. It is sufficient to say that the account given to Mr Pollak by Social Worker C was that he had been approached by a boy "probably in late 1975 or early 1976". If that account by Social Worker C was correct, and for the purposes of this Report we assume that it was, we are satisfied that the boy was R 23. Whether Social Worker C was told what was happening by R 23 as early as late 1975, we are satisfied that the police were unaware of R 23's allegations until 1976. The events relating to R 23 cannot therefore have been described in the RUC document purporting to be Reference A because no one knew about them other than those involved in the sexual activity. This information could not therefore have been available to Mr Wallace in 1974 and cannot therefore have been referred to in the RUC document described in GC80 as the background paper on Tara provided by the RUC and which was commented upon in the passage from GC80 already quoted.

552 Paragraph 10(c) also states that "the claims of a prostitution ring involving juveniles and centred on Bangor is [sic] not really substantiated, other than by Garland's personal account".[412] This presumably relates to the reference to Mr Garland in paragraph 6 where it is stated that "flag 'O'" is "Garland's own version of events." Paragraph 6 refers to Mr Garland at some length.

> "…[McGrath's] former employer, ROY GARLAND, is well known in Unionist Party circles (see also CLIFFORD SMITH) and was for some time 2i/c of 'TARA'. Admittedly, some of the personal correspondence between the two men during this period cannot be regarded as normal between employer and employee (see flag 'M'). Whatever the real reason for the row between GARLAND and McGRATH, there is certainly considerable animosity between them at present, and GARLAND has been actively engaged in trying to

411 KIN 20241.
412 KIN 35083.

have McGRATH removed from his post at Kincora. GARLAND's own version of events (see flag 'O') is, of course, very enlightening, but I would suggest that it should be treated with caution until it can be substantiated because of the antagonism between them. It would also appear that many of the RUC source reports on this matter after 1971 originated from GARLAND."[413]

553 The reference to "flag 'M'" and to the correspondence between McGrath and Mr Garland clearly relate to the letters which Mr Garland showed to DC Cullen in 1974 and which are referred to in chapter 27 from paragraph 193 onwards. We have found no evidence to suggest that in 1974 DC Cullen gave any information about Mr Garland to anyone other than ACC Meharg, and ACC Meharg gave the letters from McGrath to Mr Garland back to DC Cullen after he read them.

554 The reference to Mr Garland's "own version of events" is not elaborated, but the reference to "flag 'O'" clearly infers that a document was in existence that was either compiled by Mr Garland, or contained a record made by someone else of what Mr Garland had to say. The only documents we are aware of that could answer this description of Mr Garland's "own version of events" are the documents prepared by DC Cullen of what he learned from Mr Garland, and Mr Garland's anonymous Robophone message to the RUC of 23 May 1973. For the 1973 message to have answered the description of Mr Garland's "own version of events" the RUC background paper would have had to identify Mr Garland as the maker of the anonymous call, and then passed that information to HQNI. There is no evidence whatsoever to show that anyone in the RUC was aware in 1974 of the identity of the author of the call. We consider that the Robophone message could not therefore be what is referred to in GC80 as "Garland's own version of events".

555 DC Cullen's notes make no reference to Bangor or to youths being taken to hotels for the purposes of sexual abuse or prostitution, so the source of the information in "flag 'O'" could not have been DC Cullen. Nor could it have been anything said in the 1973 Robophone message which we have already examined and which makes no reference to Bangor.

556 Mr Garland's own comments about this passage in GC80 in his letter to the Inquiry dated 26/27 September 2016 are enlightening. Having said that "I have found Colin Wallace straight forward, intelligent and caring.

413 KIN 35082.

He knows what he is talking about", Mr Garland then quotes from the Inquiry transcript of 7 July 2016 the relevant passage from GC80 about the prostitution ring in Bangor. His document then says,

> "I never referred to Bangor in my "confidential" call, but I understand Bangor was involved.
>
> As we will see, one of the documents that's said to be available to the author is an account from Roy Garland. So Roy Garland is said in a document that is available to the author to be talking about a prostitution ring involving juveniles centred on Bangor." (this is a quotation of Counsel's remarks on 7 July 2016)
>
> Comment;
>
> Not in Bangor – I believe I said in my "confidential" anonymous telephone call that a ring existed – this was speculation based on what I saw and heard and guess work. It was an attempt to get something done."
>
> "...[McGrath] was also in sympathy with a Belfast Baptist Pastor accused of abusing two boys. I believe he did not act alone but was at least in contact with other pedophiles [sic] and probably shared some of his secrets with them. But I also understand that Bangor was involved."[414]

These remarks show that Mr Garland never mentioned Bangor at any time, and we therefore fail to see how there could have been a belief in any document that Mr Garland's own version of events was in any way relevant to the allegation in GC80 about a prostitution ring in Bangor.

557 Mr Garland and Mr Wallace had been in contact with each other before Mr Garland wrote to the Inquiry on 26/27 September 2016 as is clear from the remarks quoted above, and from the final passages in Mr Garland's document which are identical in every word to the final passages from Mr Wallace's earlier letter and accompanying submission. Had Mr Garland been aware of any document that existed in 1974 that could have answered the description of "his own version of events" in GC80 no doubt he would have said so. He has not. We consider that Mr Garland's statement does not provide any support for the authenticity of GC80; indeed it undermines the authenticity of the document.

414 KIN 130043.

Was the 8 November 1974 document sent to anyone?

558 In *Who Framed Colin Wallace?* at page 139 it is stated that:

> "[Mr Wallace] is not clear today (because he only has a copy) for whom the memo was intended, but it would certainly have gone to his Superior Officer Jeremy Railton Head of Information Policy, and almost certainly also to Army Intelligence and the Army's RUC Liaison Officer at Police Headquarters in Belfast."

559 Given that GC80, which bears Mr Wallace's signature, bears the handwritten words showing to whom it was addressed, namely Lt Col Railton, it is hard to see why there was any uncertainty on Mr Wallace's part as to the identity of the intended recipient(s). Lt Col Railton said in 1985 that he had no recollection of ever seeing this document. GC80 carries a handwritten note indicating that Lt Col Railton was the intended recipient. If Mr Wallace did not do so, who wrote this on the document? In his submission to the Inquiry sent with his letter of 9 September 2016 Mr Wallace had this to say about the document.

> "I do not know if my original document was re-typed after I submitted it to one of my superiors at HQNI in November 1974 and before it was passed on to other senior officers. I am only aware that General Peter Leng responded to the matter in a memo which instructed Information Policy to take action to ensure that the RUC took a more active part in the matters raised in the memo."[415]

560 We are satisfied that this makes it clear that Mr Wallace was saying that he did submit the document to one of his superiors, and therefore Lt Col Railton would have been the person who received it first, whatever may have happened to any such document afterwards.

561 Mr Wallace said in that passage that he did not know whether his original document was re-typed after he submitted it, and in the extract from *Who Framed Colin Wallace?* it is stated that Mr Wallace only had a copy. In 1986 Mr Wallace described the document which we believe to be GC80 as a draft, and a carbon copy of his original draft version. In a letter of 20 June 1986 to Lord Trefgarne, a Junior Minister in the Ministry of Defence at the time, Mr Wallace said that it was "the carbon copy of [his] original draft version of the one now held by your Ministry".[416]

415 KIN 124665.
416 KIN 190212.

As we have already stated, Mr Wallace was requested by the Inquiry to produce the original version of GC80 to the Inquiry and he has not done so. His 1986 description of the document as a carbon copy is important for the following reasons.

562 First of all, the carbon copy could be examined and any differences between its text and GC80 identified. Despite being requested by the Inquiry on 19 April 2016 to

> "Please produce all original versions (and not photocopies) of the memorandum – whether draft or final – for inspection by the Inquiry."[417]

Mr Wallace has ignored that request, although as will be apparent from earlier parts of this chapter he has written to the Inquiry on several occasions since then.

563 Secondly, the references to "a first draft" suggests: either (1) that as a draft the document had not reached the stage where it could be, and therefore was not, submitted to his superiors; or (2) it had been submitted before he finished work on it; or (3) there were subsequent drafts.

564 In his letter to his Member of Parliament, Mr Marshall, of 28 August 1986, and in an attachment to that letter, Mr Wallace made the following points about the authenticity of the 8 November 1974 / GC80 document.

> "As I have already made clear to Lord Trefgarne in earlier correspondence, it was nothing more than the first draft of a memorandum relating to a request I had received in 1974 to draw media attention to the overall situation relating to 'Tara', William McGrath and Kincora.
>
> The copy of the document which I have seen did not have "the names of the addressees" hand written on it and, in any event, there was only ONE addressee."[418]

565 In the letter itself, Mr Wallace referred to the question of authenticity and made the following points.

> "a. The document, was, indeed, 'authentic' in that the version published in the 'Irish Times' was entirely consistent with the memorandum written by me in 1974.

417 KIN 123327.
418 KIN 102307.

b. I have seen a photocopy of the original memorandum but, contrary to what the Kincora Inquiry said, the names of the addressees on that document were NOT hand written and, indeed, there was only ONE addressee.

c. There is no question whatsoever of the first page being tampered with nor of two typewriters being used, albeit the Forensic Report apparently claims that this is only a "possibility".

d. At no time since the document's publication in 1985 did anyone at the MoD ask me about the document or its authenticity and I find this most odd bearing in mind the apparent importance which the committee [The Hughes Inquiry] placed on it and its contents. This is even more remarkable when one considers that I was the alleged author and that I was engaged in extensive correspondence with the Department during the period.

e. I would very much like to know, however, how any alleged changes to the front page could possibly have altered the overall content of the memorandum or what the significance is of the Report's claim that two type writers were allegedly used – other than to make the alleged alteration."[419]

566 Later in the same paragraph he said,

> "Furthermore, the document's authenticity has already been confirmed independently by other sources who were aware of its existence during the period, and the 'Irish Times' report correctly claims that it was not the only official document concerning the scandal to be in circulation at the time.
>
> Despite the forgoing, the matter of the document's authenticity is important to me and I intend to pursue this at some length in due course."[420]

567 We observe at this point that in 1986 there was no reference to Mr Wallace having submitted the document for independent forensic examination. However, no doubt that may be because he has subsequently claimed that it was Mr Foot who did so and it was not until somewhere in November 1986 that it appears contact was made with Mr Foot on behalf of Mr Wallace. See the introduction to *Who Framed Colin Wallace?*

419 KIN 102294.
420 KIN 102295.

568 Of the paragraphs 'a. – e.' quoted above, 'a.' possibly and 'b.' certainly, imply that the original version created by Mr Wallace was not identical with GC80 because he says "the names of the addressees were not handwritten". If that is correct, then there must have been at least one other version in existence. If it is correct, then the question of what differences there were between the version with his signature on it that appears on GC80, and the *Irish Times* or any other version, may be important. To say that the *Irish Times* version is "entirely consistent with the memorandum written by me in 1974" is meaningless without the ability to compare the two versions. In any event, it does not deny that there were differences between his memorandum and the published version.

569 The phrase "nothing more than a first draft" from the passage already quoted suggests to us that such a document would not be submitted by the author to whoever was supposed to receive the document until it was complete. That is normally what a first draft means. We consider that would be particularly the case given the rigidly hierarchical structures within the Army in HQNI, and the rigidly formulaic form in which documents were to be submitted. The proposition inherent in all of Mr Wallace's accounts that a rough draft was submitted to General Leng does not bear examination. Yet the GC80 document bears Mr Wallace's hand written signature above his typed signature. If GC80 was only "a first draft" we are in no doubt that it would not have been signed. At the very least this suggests that for whatever reason Mr Wallace sought to show that the version which has become public was in fact the final version.

570 The position becomes even more confusing when we consider what Mr Wallace wrote to Lord Trefgarne on 20 June 1986. In that letter, Mr Wallace said that there were two versions, because he had produced a further version with a new "Reference D" added under the old Reference C.

> "From my examination of the document it is almost certainly the carbon copy of my original draft version of the one now held by your Ministry. You will have noticed that the only differences between the two versions relate to the fact that I was originally under the impression that the "Reference A" referred to was entirely an RUC paper, whereas, as I later discovered, one part of it comprised an Army analysis / commentary upon the police report. When this was drawn to my attention I amended the final memo i.e. the one which

your ministry now has, to take into account the correct attribution of source material. As a result, in your version "Reference C" has the title "Int comments upon the above" and a new "Reference D" has been added under the old "Reference C" title."[421]

571 Mr Wallace is there saying that he amended GC80 and prepared a "final memo". If there was another such version, we consider it even less likely that his signature would appear on GC80. No such final memo has ever been traced.

The authenticity of the 8 November 1974 / GC80 document

572 Having carefully considered all of the material to which we have so far referred, we are satisfied that there is an extremely strong circumstantial case that the 8 November 1974/GC80 document was not created in November 1974 as Mr Wallace maintains, but was created in the form in which it emerged in 1984 at a considerably later date. In reaching this conclusion we have taken into account all of the various matters to which we have referred in this section of the Report, and we set out the most important matters below.

a. Mr Wallace says GC80 was prepared in response to a request by General Leng. General Leng denied doing so, or ever seeing this document.

b. Mr Wallace's description of the document as "a first draft" is inconsistent with the implication of the passage we have already quoted from page 139 of *Who Framed Colin Wallace?* that the memorandum was submitted to his superiors. Why would Mr Wallace sign a document that was only a first draft?

c. The evidence of the Military witnesses to the effect that a document in that form would not have been submitted to General Leng is persuasive.

d. None of the documents referred to in the document as References A, B or C, or any of the many documents referred to therein as "flags" has been shown to have existed.

421 KIN 190212.

e. Mr Wallace could not have known of the existence of the Mason File in 1974 because it lay forgotten in Mr Bunting's drawer between 1973 and 1976.

f. No one in authority, neither the police nor Social Services, had any knowledge of Semple's abuse of residents in Kincora until 1980.

g. There were no suggestions in 1974 that residents in Kincora had been taken to hotels in Bangor to be sexually abused.

   i. Mr Garland knew nothing of that.

   ii. R 23's experiences do not support the Bangor allegations because the earliest time at which anyone in authority may have known of R 23's experiences was when Social Worker C was approached in late 1975 or early 1976.

h. Despite his many contacts with Members of Parliament and journalists about matters relating to Northern Ireland after his dismissal in 1975, GC 80 did not emerge until 1984. If it existed in 1974 there were many occasions when Mr Wallace had the opportunity to produce it.

i. There is no evidence to show that he voiced his concerns about residents of Kincora being sexually abused in Kincora to anyone in the 1970s.

573 We have also taken into account Mr Wallace's response to the Inquiry's request that he provide information and documents. His response was at first to ignore our requests. Having ignored our invitations to take part in the Kincoara Module as a core participant, and to have legal representation, if necessary at public expense, several months later after carefully studying the transcripts of the public hearings into Kincora, he sent the Inquiry a number of submissions accompanied by much documentary material. Almost all of his submissions and the accompanying material had little or no bearing on the issues the Inquiry has identified, both in correspondence to Mr Wallace, and in the published transcripts of our hearings. Mr Wallace has chosen not to answer our questions or provide the documents we requested. We can conceive of no good reason for his not doing so. Mr Wallace has engaged with the Inquiry in a fashion which demonstrated that, as he has done over the years, he is adept at avoiding pertinent questions by drawing attention to other matters which do not deal with the questions he has been asked by this Inquiry, by the Hughes Inquiry or by the Police about his allegations.

PART SIXTEEN

Mr Wallace's letter to the IPCS

574 In 1975 Mr Wallace was represented by Mr Cliff Crook of the Institution of Professional Civil Servants (IPCS) at his appeal to the CSAB against his dismissal. Among the documents sent to the Inquiry with his letter and submission of 9 September 2016 was a photocopy of a letter he says he sent to Mr Crook dated 29 September 1975. In his letter to the Inquiry of 26 September 2016 Mr Wallace referred to this letter to Mr Crook, and to an article in the *Guardian* on 30 May 1990. The relevant passage from the letter to Mr Crook is in the following terms.

> "My concern now is that there may be an attempt by the Ministry to deny any form of official 'dirty tricks' organisation existed within the Security Forces. For example in the Ministry's summary of my oral representations made to John Groves and Mr Fairbairn on 10 May reference is made in paragraph 3 to "actions" which I was asked to launch during the UWC strike. The word "actions" appears to have been used by MoD to conceal the fact that I referred to the attempts made by the Security Service to discredit various Loyalist Politicians, including the Rev Ian Paisley by the use of forged documents and by linking the MPs with Loyalist Paramilitary figures involved in homosexual prostitution at a children's home in Belfast. [his emphasis] I can fully understand why the Ministry would not want to put such information on record, but I wonder if evidence of that nature will be made available to the Board sub-rosa.
>
> It is clear from the above, therefore, that, within six months of leaving Northern Ireland and some 5 years before the Kincora story surfaced in the Irish Independent, I had been referring to homosexual prostitution at a children's home in Belfast."[422]

575 Whilst the words underlined by Mr Wallace refer to "homosexual prostitution", the children's home is not named. Loyalist figures could include McGrath, but "homosexual prostitution" at Kincora was not what Mr Wallace said in the 8 November 1974 document. At paragraph 4 of the document he refers to Kincora and to "allegations of homosexual assaults on inmates at the hostel".[423] The use of the term "prostitution"

422 KIN 124805 and 124806.
423 KIN 35081.

implies that money or money's worth changed hand in return for sexual services. That is very different from "allegations of homosexual assaults on the inmates" of Kincora.

576 At paragraph 10(c) of the document he refers to "the claims of a prostitution ring involving juveniles and centred on Bangor". The reference in the letter to Mr Crook to "homosexual prostitution at a children's home in Belfast" does not therefore sit easily with the references to Kincora and Bangor in the 8 November 1974 document he claims he compiled less than a year before.

577 The failure of Mr Wallace to refer to Kincora by name is also curious in view of his present belief that his dismissal was due to his knowledge of what was happening in Kincora. If that was his belief in 1975, the failure to refer to Kincora in this letter, or during the hearing before the CSAB, is all the more surprising. If Mr Wallace was then so concerned about Kincora to make a phone call, which he says he did to Social Services in 1975, why did he not refer to Kincora and the abuse of children there in a clear and unambiguous fashion, rather than what at best appears to be an oblique and indirect way if it is even a reference to Kincora.

578 In the extract from the 29 September 1975 letter quoted above, Mr Wallace also refers to the oral representations he made to John Groves and Mr Fairbaim on 10 May 1975, implying that he told them about the linking of MPs "with Loyalist Paramilitary figures involved in homosexual prostitution at a children's home in Belfast". In fact the oral representations were not made on 10 May but on 30 May 1975 as Mr Wallace correctly stated in his comments on the notes dated 5 June 1975.[424] The document was incorrectly dated 10 May, an error Mr Wallace perpetuates in the 29 September 1975 letter. Given his invariable practice of pointing out mistakes and omissions he says have been made by others, if he had made such a reference during his oral representations we believe that he would have insisted that it be included. That he did not so insist suggests to us that no such references were made during the oral representations. More importantly, Mr Wallace's notes of amendments to the record of representations make no reference to homosexual prostitution at a children's home in Belfast, notwithstanding that he meticulously listed his observations and corrections to the text on 5 June 1975.[425]

424 KIN 102081.
425 KIN 102080.

579 In 1990, in the aftermath of the Ministerial Statement to the House of Commons to which we have already referred, Mr Wallace complained to the Metropolitan Police about the actions of the MoD during the CSAB appeal process. As part of the complaint his solicitor sent to the Metropolitan Police a file of papers including Mr Wallace's correspondence with Mr Crook relating to the appeal. The Inquiry has obtained a copy of the file and examined the schedule of the documents sent to the police. The schedule can be found at KIN 200028 to 200032. The letter of 29 September 1975 does not appear on that list, nor is there any reference to that letter in any subsequent correspondence between Mr Crook and Mr Wallace contained within the file. We are surprised that the file sent to the Police did not contain the letter of 29 September 1975.

580 We have taken into account all the matters to which we have referred in relation to the 29 September 1975 letter when considering its authenticity, and when we consider the overall credibility of Mr Wallace's accounts of what he knew, and what he did, about the sexual abuse of residents in Kincora from 1972 onwards.

Other witnesses whose evidence may be relevant

Michael Taylor

581 Mr Taylor was born in 1938, and in 1963 moved to Northern Ireland. He joined the ACF in 1965 and got to know Mr Wallace through the ACF. In 1968 he was one of Mr Wallace's referees when Mr Wallace joined the AIS. In December 1970 Mr Taylor applied to join the AIS and Mr Wallace was one of his referees. Mr Taylor was ultimately successful in his application, and took up his appointment with the AIS as an Information Officer on 1 March 1972. He served in that capacity at HQNI from 1972 until he was posted to Berlin in January 1976.[426] His main responsibility at HQNI was as the editor of VISOR, a newspaper for Army personnel serving in Northern Ireland.[427]

582 On 9 June 1982 he was interviewed during the Caskey Phase Two investigations, when he had the following to say about Kincora.

> "I have been asked if I ever heard about Kincora Boys' Home in my capacity whatsoever. I had never seen any official document, to my knowledge, on Kincora Boys' Home although I do recognise as a

426 KIN 190054.
427 KIN 190055.

result of the situation that prevailed in Northern Ireland at this time, it may have been discussed verbally. If Wallace may have discussed Kincora with me, I cannot remember any specific detail. The names McGrath and McKeague mean something to me, although I cannot connect McGrath with any verbal conversation regards Kincora. I did not know that McGrath worked at Kincora Boys' Home, but his assumed association with the Protestant Military Organisation called 'TARA' was on record."[428]

583 On 28 March 1990 the ITN Channel 4 News Programme carried a report on the allegations relating to Kincora. Mr Taylor was one of those who was interviewed. In the course of the interview he referred to two documents, and it is clear that one was the 8 November 1974 memorandum. In the following passages from the transcript the interviewer is Robert Parker. Having referred to Mr Wallace producing two memos Mr Parker introduced Mr Taylor. The transcript continues.

"Michael Taylor: They formed a file that had been established on the… all aspects of Kincora, in which we had discovered various events going on there and those events related to the possible attraction of paramilitaries and consequently the Army intelligence put together a documentation file of Kincora itself.

Robert Parker: You have no doubt at all that you've seen these documents before in 1973 and 1974.

Michael Taylor: No doubt whatsoever."[429]

584 Mr Taylor's assertion that he had seen the 1974 document as part of a file is completely at variance with what he had said in his 1982 police statement.

585 The interviewer then refers to the 1974 memo in terms which make it clear that he is referring to the GC80 document because of the references to three sources of material, the first being "reference A, an RUC background paper on Tara." After a number of quotations from that document Michael Taylor says.

"The document attached to the memorandum was signed by Sir Peter, endorsing the document to say that he agreed with the conclusions of the memorandum and that the appropriate authorities should be

428 KIN 30133.
429 KIN 80368 and 80369.

notified and take action. His recommendation was that this should be brought to the notice of the RUC who were the correct body for carrying out any further investigations, and if necessary, prosecuting the people concerned."[430]

Mr Taylor's assertion that General Leng saw the 8 November 1974 document and signed a note endorsing it contradicts what he said to the police in 1982, and raises the question that if General Leng did endorse Mr Wallace's memo in writing, why was it that Mr Wallace was unaware of that endorsement of his recommendations throughout the 1980s when he made no reference whatsoever to that? We consider it significant that there is no reference in *Who Framed Colin Wallace?* to any such endorsement by General Leng in either the 1989 first edition or the 1990 paperback edition. In the forward to the 1990 edition Mr Taylor is described as a staunch supporter of Mr Wallace. As the book makes clear, Mr Taylor was interviewed by Mr Foot on several occasions. If Mr Taylor had seen the document and the document added in the form of a written endorsement by General Leng we are satisfied that it is inconceivable that he would not have made that known to Mr Wallace and/or Mr Foot long before the Channel 4 News Programme of 28 March 1990.

586 In his submission to the Inquiry sent with his letter of 9 September 2016 Mr Wallace claimed that in the recorded interview of General Leng in 1990 the General recalled writing a memo. We have already examined the full transcript and we do not need to repeat what is said there. The following extract is sufficient.

"Penrose: You said in the memo according to [Mike] Taylor that the RUC and the Social Services I think ought to be brought in here because the file named men and boys who were obviously part of this abuse which we all know about since.

Leng: Yes, I recall that.

Penrose: Do you? And you said take action. They waited because obviously there had been other members suggesting this from junior officers, [sic] but it was yours that finally convinced Taylor that this was going to happen, but of course it went on for another six or seven years, but again that wasn't your fault."[431]

430 KIN 80370.
431 KIN 124651.

587 Mr Wallace claimed in his submission to the Inquiry sent with his letter of 9 September 2016,

> "I do not know if my original document was retyped after I submitted it to one of my superiors at HQNI in November 1974 and before it was passed on to other officers. I am only aware that General Peter Leng responded to the matter in a memo which instructed Information Policy to take action to ensure that the RUC took a more active part in the matters raised in the memo."[432]

588 Mr Wallace does not say how he is aware that General Leng responded in a memo, but this is an obvious reference to Mr Taylor's version of events. Again we regard it as inconceivable that Mr Wallace was and is unaware of Mr Taylor's assertions in the March 1990 Channel 4 Programme. If what Mr Taylor said in that programme was correct this was a vital and highly significant piece of corroboration of Mr Wallace's accounts, but Mr Taylor's 1990 account is irreconcilable with, his 1982 police statement. We also are satisfied that it is incompatible with the accounts Mr Wallace gave throughout the 1980's, none of which contained any such assertion. We do not consider Mr Taylor's account in the 1990 Programme to be credible.

Fred Holroyd

589 Mr Holroyd has been closely associated with Mr Wallace since the early 1980s, and has corresponded with the Inquiry in support of Mr Wallace. As we have stated earlier in this chapter, Mr Holroyd has made allegations about Army misconduct in Northern Ireland relating to knowledge he gained during his service in Northern Ireland. These matters do not relate to Kincora. The only matter that does relate to Kincora relevant to him, concerns an entry he made in a notebook.

590 Mr Holroyd made two statements to the police in 1982 during the Caskey Phase Three investigations. The first was on 22 May 1982 and made to an officer of the Royal Military Police Special Investigation Branch. In that statement he explained that he served in Northern Ireland between 7 January 1974 and June 1975 as an MIO (Military Intelligence Officer) attached to the RUC J Division, which covered south Armagh. He explained that his duties required him to have close contact with RUC Special Branch and Criminal Investigation Departments. He described his knowledge of Kincora and Mr Wallace at that time.

432 KIN 124665.

> "I am unable to be specific but I would estimate that during the middle of my tour the name 'Kincora' came to my attention. I understood that Kincora was a home, (probably run by the Social Services in N Ireland) for boys.
>
> To the best of my recollection I became aware of 'Kincora' through recreational conversation in RUC stations. It certainly did not come to my notice through any official briefing or intelligence and I did not attach any significance to 'Kincora'.
>
> The only information which came to my attention was that of rumour to the effect that a homosexual liaison had been formed between certain leading politicians and a number of boys in the home. This was general talk on occasions when I was in company with RUC officers. I am unable to recall any police officer by name who mentioned the events or alleged events at 'Kincora'. It was not my understanding that this had ever been the subject of an official complaint to the RUC.
>
> I did not attach any significance to this information and did not on any occasion pass the rumour about 'Kincora' to my direct superior in the Army nor to any other officers in HQ Northern Ireland.
>
> I do not think there was any official police inquiry into 'Kincora' at that time. I am not acquainted with Colin Wallace. I was not getting any military intelligence from anyone working or involved at Kincora and my knowledge of the subject is limited to what I have outlined in this statement."[433]

591 On 8 June 1982 he made a further statement, this time to DI Mack of the RUC. In it he said that since the previous interview and statement that he had made

> "...I have found a reference to Kincora in my notebook. The note is undated but was made in May 1973 prior to the 13th. It states 'Kincora Belfast – Rev Smyth's, Paisley's lot – queers'. As far as this entry is concerned I did not act on it as it was rumour and meant nothing to me. I do not know who gave me this information but I may have got it from someone in Portadown Police Station. ...I did not hear anything about Kincora at any other police establishment. I have given thought to who may have talked to me about Kincora. I have the feeling it may have been Detective Sergeant McMahon but on this point I'm not sure."[434]

433 KIN 30164.
434 KIN 30165.

592 Whilst the notebook entry appears in the notebook prior to 13 May 1973, as Mr Holroyd's tour of duty in Northern Ireland did not start until 7 January 1974 he must have made the entry sometime between 7 January 1974 and June 1975. It appears as if he made use of an old diary as a notebook on that occasion, whenever that occasion was. The entry itself "Kincora Belfast – Rev Smyth's, Paisley's lot – queers" says nothing about sexual abuse of children in Kincora. The references are indicative of jottings containing rumours about Tara of the type we have already examined in the Special Branch document of 17 April 1973 which referred to McGrath as a reputed homosexual.[435] Other relevant information was contained in the Special Branch report of 5 July 1974, which referred to McGrath as a house father at Kincora hostel.[436] Mr Holroyd's recollection in 1982 of what he believes he was told during his tour of duty in Northern Ireland does not gain any additional support from the terms of the notebook entry. We have taken Mr Holroyd's 1982 account of his recollection of events in 1974 to 1975 into account when examining the issues relating to Kincora and when examining Mr Wallace's credibility.

Relevant opinions as to Mr Wallace's credibility in relation to other matters

593 Mr Wallace has frequently pointed to comments made upon his evidence by Mr Justice Barron who conducted an Inquiry into the Dublin and Monaghan bombings. He has also referred to the Saville Inquiry into Bloody Sunday. He has put forward both as supporting his general credibility. For example, in his submission to the Inquiry he quotes the following assessment of him by Mr Justice Barron in support of his criticism of counsel to the Inquiry for saying that Mr Wallace's evidence to that Inquiry had been rejected.

> "In a personal assessment of me and my evidence, Judge Barron said;
>
> "In person, Wallace comes across as intelligent, self assured, and possessed of a quiet yet unwavering moral conviction. Though he has reasons enough to be bitter – the abrupt and unjust ending of a promising career in Northern Ireland, five years spent in prison on a conviction which has since been quashed – he displays no outward

435 KIN 55076.
436 KIN 55081.

> signs of resentment towards individuals or institutions. He remains intensly loyal to his country and to the Army: In so far as he has a quarrel, it is with individuals rather than the institutions concerned. He says he believes that much of the propaganda work undertaken by Information Policy was justifiable in the interest of defeating subversives and promoting a political solution to the troubles. When speaking of matters directly within his own experience, the Inquiry believes him to be a highly knowledgeable witness. His analyses and opinions, though derived partly from personal knowledge and partly from information gleaned since his time in Northern Ireland, should also be treated with seriousness and respect".[437]

However, at page 163 of his interim 2003 Report Mr Justice Barron made the following pertinent point about Mr Wallace.

> "The covert nature of Mr Wallace's work, and his experience in manipulating truth and untruth to serve particular ends makes it especially difficult to assess the worth of his allegations..."

594 Mr Justice Barron gave evidence to the Joint Committee on Justice, Equality, Defence and Women's Rights of the Oireachtas (The Irish Parliament), which was set up to consider the Report of his Independent Commission of Inquiry into the Dublin and Monaghan bombings. The final Report of the Joint Committee records Mr Justice Barron's views on Mr Wallace's claims about collusion between some of those involved in the bombings and RUC Special Branch and Military Intelligence.

> "2.13 Mr Justice Barron also quoted from a letter from Mr. Colin Wallace, former British Army Senior Information Officer in Army Headquarters, to a former colleague, in which he wrote on 14 August, 1975:
>
> > '...There is good evidence that the Dublin Monaghan bombings were a reprisal for the Irish Government's role in bringing about the Executive. According to one of Craig's people, some of those involved the Youngs, the Jacksons, Mulholland, Hanna, Kerr and McConnell were working closely with SB and Int at that time.'
>
> Mr Justice Barron remarked in his Report that Mr. Wallace was making these allegations as early as 1975, but noted that his letter does not contain any objective evidence to support the claims...

437 KIN 124644 and 124645.

> 2.14 Even taking into account all the information received from Colin Wallace, John Weir and Fred Holroyd, Mr. Justice Barron felt he could not go beyond the conclusions reached in his report in relation to collusion."[438]

595 We are satisfied that it is clear from these passages that Mr Justice Barron was not persuaded by Mr Wallace's evidence, and we consider that counsel was justified in describing Mr Wallace's evidence to the Barron Inquiry as "rejected".

596 Mr Wallace also calls in aid his evidence to the Saville Inquiry into Bloody Sunday. The Saville Inquiry dealt with his evidence at 9.214, 9.215 and 9.217.

> "9.214 Colin Wallace, who in January 1972 was a civilian Army Public Relations Officer based at HQNI, gave evidence to this Inquiry that Unionist Politicians took an entirely different view of events at Magilligan Strand and were furious at the apparent inability of the Parachute Regiment to deal effectively with the marchers. His recollection was that the Stormont Government was very concerned about the adverse reaction of Protestants who saw on television images of apparently illegal marches unchecked by the security forces. Colin Wallace stated that complaints from Unionist Politicians to Downing Street led to the Ministry of Defence issuing a directive to the effect that the scene such as those at Magilligan should never again appear on television screens.
>
> 9.215 No documents have been found that provide support for this evidence of Colin Wallace.
>
> 9.217 In these circumstances, we are of the view that we cannot rely on Colin Wallace's evidence on this point. We consider that his recollection in this regard is faulty."[439]

597 Again we are satisfied that counsel to the Inquiry was justified in describing Mr Wallace's evidence to the Saville Inquiry as having been rejected.

598 Although Mr Wallace has sought to rely upon the favourable view expressed of him by Mr Justice Barron, and by his evidence to the Saville Inquiry, it can be seen that on crucial matters his evidence was not accepted by either Inquiry.

438 http://www.dublinmonaghanbombings.org/DubMonFinal.pdf, pp.19 and 20.
439 KIN 124618.

599 Mr Wallace has sought to portray these as judicial commendations of his reliability, and we therefore consider it appropriate to recall the comments made by the Lord Chief Justice of England and Wales in the course of delivering the judgement of the Court of Appeal (Criminal Division) when quashing Mr Wallace's conviction for the manslaughter of Jonathan Lewis, and considering whether to order that Mr Wallace face a retrial.

600 At page 11 of the Judgment Lord Bingham said.

> "There can be no doubt but that the appellant's [Mr Wallace] dishonest and deceptive course of conduct raised and raises a formidable case against him. It may be that even if directed in accordance with the most recent authorities and on the facts as they have now emerged, a jury would still have convicted and properly convicted. ...it seems to us possible, even if unlikely, that the appellant initially withheld reference to his meeting with the deceased out of a desire to conceal the subject matter of that meeting; and from that moment onwards he found himself drawn into an ever-increasing spiral of deception."[440]

Conclusions as to Mr Wallace's credibility

601 Because of the complexity of the various matters to which we have referred and which relate to Mr Wallace, we dealt separately and in some detail with different matters relating to the accounts he has given over the years about Kincora. Looking at these matters in their entirety we reached the following conclusions.

1 Mr Wallace was an extremely energetic and hardworking member of the Army Information Service who earned high commendations for his work from his superiors.

2 Part of that work involved him in fabricating untrue information and forging documents to provide supporting evidence for the false information.

3 He did this with the knowledge and approval of some, though not all, of those with whom he worked.

4 Mr Wallace was proud of his effectiveness and considerable ability in disseminating false information and creating forged documents.

440 KIN 122068.

5 In addition to his conventional duties in providing information to, and answering questions from, journalists he was also leaking information and documents to journalists about matters that he knew should not have been disclosed, because he admitted passing a classified document to Mr Fisk and to giving Mr Fisk information about helicopter spares.

6 The investigation carried out in 1974 by the Security Service at the request of the Northern Ireland Office produced strong circumstantial evidence to show that Mr Wallace had leaked other documents as well.

7 The contemporary records to which we have referred relating to discussions at the highest level show conclusively that Mr Wallace was not dismissed because of anything he claims he knew about Kincora but because he was believed to be leaking documents.

8 We are satisfied that Mr Wallace knew in 1975 that that was the sole reason for his dismissal, and he knows now that his dismissal had nothing whatever to do with Kincora.

9 Mr Wallace made no reference at the time of his dismissal, or in the weeks and months afterwards, to any concern he had about Kincora when he was contesting his dismissal.

10 Following his dismissal the MoD deliberately interfered with the CSAB process to secure a favourable outcome. As Mr Wallace justifiably said they "rigged" the proceedings.

11 Mr Wallace's concerns at the time related not to Kincora, but to the denial by the MoD of the full range of his responsibilities. Whether he was justifiably dismissed or not, the MoD deliberately chose not to disclose his full range of responsibilities as shown in the draft Job Specification.

12 This failure, and the secret briefing of the chairman of the CSAB, constituted major injustices which were not recognised and corrected until he was paid £30,000 compensation following the investigation by Mr Calcutt QC in 1990.

13 Mr Wallace was not concerned about Clockwork Orange or Kincora at the time of his dismissal; his concerns about Clockwork Orange surfaced later.

14 He was proved right to some degree at least that Clockwork Orange existed, when the MoD eventually admitted in 1990 that there had been a Clockwork Orange proposal, although this had been denied for many years.

15 At three crucial periods in his life Mr Wallace lied to the police. The first was when he was questioned in 1975; the second was when he was under investigation after the death of Jonathan Lewis; and the third was when he lied to D/Supt Caskey when questioned about the murder of Brian McDermott. He showed himself to be someone who is prepared to lie when it suited him.

16 Key aspects of his accounts of his knowledge of, and actions in respect of, sexual abuse at Kincora cannot be corroborated by anyone. His account of how he came to learn about sexual abuse at Kincora by meeting the Social Worker does not appear plausible, there is no record of him contacting Social Services in 1975, and those to whom he claims he spoke about Kincora after his dismissal have denied that he did so.

17 Between 1976 until his arrest in 1980 he was in frequent contact with Members of Parliament and with journalists, but none of the contemporary documents show that he raised Kincora in any way, nor did those to whom he said he spoke in some manner or other about Kincora and sexual abuse support his evidence.

18 During this period, although he had ample opportunity to do so, and might have been expected to do so if he really was concerned to prevent further abuse of residents of Kincora, the 8 November 1974 document was never referred to or produced until it emerged in 1984, many years after it purported to have been created.

19 Over the years he has consistently avoided answering relevant questions about his knowledge and the 8 November 1974 document when asked to do so by the police, by the Hughes Inquiry and by this Inquiry. Instead of answering pertinent questions frankly and openly he has reacted by seeking to divert attention by conflating matters such as Clockwork Orange and Kincora, and referring to matters that are of no relevance to the issues about which the police, the Hughes Inquiry or this Inquiry sought to obtain information.

20 The 8 November 1974 document is central to Mr Wallace's credibility. No credible witness ever saw it in and around the time when, if Mr Wallace is correct, it must have gone through several hands including those of Sir Peter Leng.

21 There are many other unanswered questions about this document, such as its layout, and the confusing and changing accounts as to how many drafts there where, or whether the document was ever submitted, and if so to whom and in what state.

22 Above all, several important pieces of information contained in, or referred to in, that document either did not exist at the time, such as the allegations clearly referring to R 13, or could not have been known to Mr Wallace in 1974 as in the case of the Mason File.

23 We do not accept that the 8 November 1974 document as contained in GC80 was created in 1974, and we are satisfied that it was created long after November 1974.

602 Taking all of these matters into consideration we are satisfied that Mr Wallace cannot be regarded as truthful in his accounts of what he knew about sexual abuse in Kincora, or what he did with that knowledge, in 1972 to 1974.

PART SEVENTEEN

Visits by officials to Kincora

603 At page 145 of his book *The Kincora Scandal*, Chris Moore refers to an account by a former Military Intelligence Officer he refers to as "Dennis" driving a civilian to Kincora "at the end of 1975 or early in 1976". The Inquiry has been able to identify "Dennis", and at the Inquiry's request the MoD traced Dennis who provided a witness statement to the Inquiry. In it he described how he was instructed to drive an unnamed visitor to East Belfast. He collected his passenger at HQNI at night, he believes around 7pm. At his passenger's direction he drove to a house in East Belfast that he now knows to be Kincora. His passenger entered the building where he remained for a period which Dennis describes as not being sufficiently longer or shorter than an hour, i.e., approximately one hour. When his passenger emerged Dennis drove him back to HQNI.

604 His passenger did not identify himself, but Dennis said he formed the impression his passenger was most probably civilian rather than military, something he thought little of at the time. Dennis described the man as,

> "...aged approximately mid-40s with somewhat curly dark hair, about 5ft 7 inches in height, slim build, pointed features and wearing what appeared to be a suit under a fawn coloured raincoat".[441]

This description of the episode conveys a remarkable grasp of detail of an otherwise unremarkable event 40 years before, even allowing for the possibility that Dennis was able to refresh his memory from the account he gave to Chris Moore in the course of Mr Moore's researches for *The Kincora Scandal*. It may be that there was a visit, but some of the detail may have been affected by the passage of time. If Dennis's account is reliable, it suggests that the Army provided transport to and from Kincora, probably in early 1976, to a person who wished to visit what was by then known to several agencies to be McGrath's place of work. That such an occasion occurred cannot be ruled out. There are two possible explanations for such a visit. The first is that there was a political, or security, intelligence purpose for the visit. Although Tara was believed to be of peripheral importance in early 1976, that does not mean it was necessarily of no importance. We cannot exclude the

441 KIN 5073.

possibility that an official might wish to speak to McGrath about political matters, unlikely though that may appear to be in the light of all the references to which we have referred in which it is said that little was known of Tara in early 1976.

605 The other reason could be that it was for some form of sexual assignation or enquiry. Such a reason appears highly unlikely in view of all the evidence we examined in chapter 26 to the effect that none of the residents recall visitors by men coming to the building for such purposes.

606 If there was such a visitor, it cannot have been the occasion described by Richard Kerr. In chapter 26 we examined his description coming home early from school one day and entering a room with three men in it. Richard Kerr was at Kincora from July 1975 when he was fourteen and he reached the school leaving age of 16 in May 1977 when he was still living there. He was therefore a resident of Kincora during the winters of 1975 to 1976 and of 1976 to 1977. His account was that he came home early from school because it was snowing, so he must have returned in daylight hours. The visit described by Dennis was at night, after 7pm when it was dark.

607 As we have explained, Richard Kerr has alleged that he was sexually abused by Sir Maurice Oldfield, but the description of his passenger given by Dennis makes it clear that the passenger was not Sir Maurice Oldfield. As can be seen from the photograph that accompanied his obituary in The Times of 12 March 1981 he was not slim, did not have dark curly hair, nor had he pointed features. By early 1976 he was 61 because he was born in November 1915.[442]

Sir Maurice Oldfield

608 Apart from the allegation by Richard Kerr, allegations were made in the media after his death that Sir Maurice Oldfield visited Kincora, and/or had contact with McGrath. Sir Maurice Oldfield was a member of the SIS from 1947 and became Chief of the Service in 1973 and remained as Chief until he retired in January 1978. In October 1979 he was asked by the Prime Minister to take on the newly created post of Security Coordinator in Northern Ireland. Because of the risk to his life that this post, and his previous history, created, he was assigned police officers in London who guarded his flat, and others who accompanied him when he left the flat. As the result of a casual conversation with the porter on

442 KIN 104320.

the desk of the block of flats in which Sir Maurice lived that took place in November 1979, one of Sir Maurice's protection officers was told that Sir Maurice was homosexual. The protection officer immediately reported this conversation to his superiors in the Metropolitan Police. The Commissioner of the Metropolitan Police reported this matter to the Home Secretary, who informed the Prime Minister. On 22 November 1979 the Secretary to the Cabinet wrote to the Permanent Undersecretary of the Home Office that the Prime Minister had decided that Sir Maurice's appointment should not be extended, and should be brought to an end as soon as reasonably possible.[443]

609 His appointment was terminated soon afterwards and Sir Maurice returned to private life in 1980. He soon became gravely ill and died aged 65 on 11 March 1981. Despite the necessity for dispensing with his services because of the revelation of his homosexuality, the Prime Minister wrote to him thanking him for his public service to which he replied on 25 June 1980.

610 Because of the nature of his admissions and the concerns that these created that he may have been vulnerable to blackmail by foreign intelligence services there was considerable concern about the nature and extent of his homosexuality. In March 1980 he denied to the Secretary to the Cabinet that he was a practising homosexual, nevertheless a direction was given that a full review should be undertaken of his Positive Vetting clearance. An investigation was then carried out by MI5. The investigation included thirteen interviews of Sir Maurice between 25 April 1980 and 7 January 1981 during which his life since leaving school was thoroughly investigated.

611 The Director General of MI5 reported the outcome of the investigation to the Secretary of the Cabinet on 19 February 1981. In his letter to the Secretary of the Cabinet of 19 February 1981, Sir Howard Smith, the Director General of MI5, observed that whilst Sir Maurice:

> "…revealed further details of his homosexual activities during the investigation, it is probable he did not admit the full extent of those activities. It is clear that he was not very discreet in his homosexual relations and that he laid himself dangerously open to compromise [by foreign intelligence services] through his admitted homosexual relations with hotel stewards in the Far-East during the 1950s."[444]

443 KIN 104314.
444 KIN 104317-104318.

612 It is against that background of a possible, if not probable, failure by Sir Maurice Oldfield to disclose every aspect of the homosexual activities in which he had engaged that the Inquiry has examined the allegations that he may have visited Kincora, had dealings with McGrath, or may have had homosexual relations with residents of Kincora, whether as Head of the Secret Intelligence Service from 1973 until his retirement in January 1978, or during his subsequent period as Security Coordinator in Northern Ireland from October 1979.

613 One of the matters raised with him during an MI5 interview on 28 March 1980 was whether he had homosexual relations after he took up his position as Security Coordinator, to which he replied that it was quite impossible for him to have any such relations from the time he took up the "Irish appointment" and was placed under guard.[445] Insofar as that remark may have included homosexual relations in London during his time as Security Coordinator that was almost certainly untrue as the circumstances which led to the discovery of his homosexuality suggest.

614 Nevertheless, so far as his time in Northern Ireland as Security Coordinator was concerned, while he was physically present in Northern Ireland Sir Maurice Oldfield was closely guarded for his own safety. His private secretary during his time as Security Coordinator explained to the RUC in 1982 that:

> "For security reasons Sir Maurice always travelled in Northern Ireland with a police escort and was accompanied by police officers whenever he left the Stormont Estate."[446]

It would therefore have been extremely difficult for Sir Maurice Oldfield to have visited Kincora, or to have homosexual relations with anyone in Northern Ireland, without such a visit being known to his private secretary or the police officers who accompanied him, or without such relations being suspected.

615 SIS provided the Inquiry with a hand written note on a document created by another SIS Officer in 2001. The handwritten note reads:

> "MO was in N. Ireland at the time".

This follows immediately after an entry which reads:

> "[redacted] Colin Wallace the Army Officer engaged in psyops in N. Ireland in the 70s. He went to prison on a manslaughter

445 KIN 105274.
446 KIN 1987.

> conviction. On release he attempted to clear his name. It was a cause celebre".[447]

616 The Inquiry asked SIS to identify any material in SIS records that would enable the meaning of the comment, or what it referred to, to be understood. SIS have told the Inquiry that the writer of the hand written paragraphs on the document is unknown, and the person who composed the type written note upon which these words were written left the Service in 2001, and efforts to contact the author had been unsuccessful.[448] In 2001 someone in SIS appears to have believed that Sir Maurice Oldfield was in Northern Ireland in the 1970s, but the basis for that belief, and whether it was accurate or not, have not been established. If the SIS are correct, Sir Maurice would not have arrived in Northern Ireland until long after Colin Wallace left, in which case the unknown author of the note was mistaken. In their response to the Inquiry Warning Letter SIS suggested that it was more likely that the annotation was no more than a 'flag' for the writer or someone else to follow up at a later stage, and that there being nothing to pursue the matter required no further comment.

617 SIS Officer F worked in the IJS on behalf of SIS at HQNI from 1973 to 1975. His statement to the Inquiry suggests that Sir Maurice did not visit Northern Ireland in the early years of his period as Head of the SIS. However, Officer F's statement does not assist in establishing whether Sir Maurice may have done so from 1975 to 1979 after Officer F's service in Northern Ireland.

618 Whilst on balance the absence of any reference in the SIS records to Sir Maurice Oldfield being in Northern Ireland before he became Security Coordinator in 1979 is indicative that he was not, however, the absence of an explanation for the note to which we have referred means that we cannot put the matter any higher than that.

The 2011 SIS note

619 In 2011 SIS Officer G examined four ring binders with material relating to Sir Maurice Oldfield, including the 1980 MI5 investigation. Officer G made the following comments at the start of his note.

> "The relationship [Oldfield] had with the Kincora Boys' Home (KBH) in Belfast and subsequent 'rent boy sex scandal' is, in my view the only remaining potential sensitivity in the papers.

447 KIN 3646.
448 KIN 3647.

> The sensitivity being that [Oldfield] may have a link to (by association through his friendship of the KBH Head) of the alleged crimes at the boys' home. Given the current climate surrounding similar cases, it may at some point emerge as an issue."[449]

620 Paragraph five of the paper written by Officer G contains the following comment.

> "More worryingly is the small collection of papers in file three which relate to the relationship [Oldfield] had with the Head of the Kincora Boys' Home (KBH) in Belfast."[450]

621 The reference to a friendship with the Head of the KBH, obviously the Kincora Boys' Home from the context, is potentially significant because, if correct, it is utterly at variance with the mass of evidence examined by the Inquiry suggesting that there could not have been any such relationship or friendship.

622 SIS Officer A has stated to the Inquiry that this was explored further with SIS Officer G in 2014 having reviewed his 2011 note, and the underlying material. Officer G commented:

> "Having been given full access to the papers, though my focus was on volumes 1-3, I conclude that my original statement was imperfectly drafted. As it stands this particular sentence is at odds with that which immediately follows it. This institution became the focus of press allegations of a homosexual vice ring – [Oldfield] was never implicated."[451]

This appears to infer that when he drafted the 2011 note Officer G did not make it sufficiently clear in the opening sentences that what he was referring to were allegations relating to Sir Maurice Oldfield, and not to material from which it might be inferred, or confirmed, that the allegations might be true.

623 This was a highly contentious issue that had received a great deal of attention inside the SIS on occasions in the past, quite apart from equally detailed attention in other Government departments, as well as critical comments in Parliament and elsewhere. We were not impressed by the bland reference to the document being "imperfectly drafted", and consider that the lack of care shown merits criticism.

449 KIN 3639.
450 KIN 3640.
451 KIN 3641.

624 The Inquiry has examined all the material held by SIS relating to Sir Maurice Oldfield as described by SIS Officer A in his statement of 8 December 2016 and found nothing to indicate that Sir Maurice Oldfield ever visited Northern Ireland before he took up his appointment as Security Coordinator in October 1979.[452]

625 Having reviewed all of the evidence we are satisfied that the allegations about Sir Maurice Oldfield's connections with Kincora have no substance.

Clifford Smyth

626 For several years Clifford Smyth was closely associated with William McGrath, both personally and politically. As we have seen from many of the documents examined, and as he accepted in his statement to the Inquiry of 5 July 2016, Clifford Smyth was closely associated with McGrath in Tara for several years. In addition, for some five years from about 1968 until he left in 1973 to get married, he was a paying lodger in the McGrath household where McGrath lived with his wife and three children.[453] Mr Smyth told the Inquiry that he did not suspect McGrath of abusing his position in Kincora, and no claims or rumours that McGrath was abusing his position in Kincora ever came to his attention until after 1980.[454]

627 In 1996 Mr Smyth contributed a lengthy forward to Chris Moore's *The Kincora Scandal*. He said.

> "Furthermore, the police knew that McGrath had been instrumental in founding an organisation called Tara. There is evidence to suggest that this organisation may have been controlled and manipulated by British Intelligence for its own ends.
>
> This book will argue that in forming Tara, William McGrath acted on the directions of his Intelligence handlers and that he set in motion events which led directly to the emergence of loyalist paramilitarism or counter-terrorism. He was not alone; others served similar ends. The questions that such evidence raises are devastating. Did British intelligence maintain a shadowy but firm control over loyalist paramilitarism from the early 1970's onwards? Were the innocent lives and future prospects of male adolescents sacrificed to the cynical manipulation of one of the most mysterious and intriguing figures to emerge from the tragedy of Northern Ireland?"[455]

452 KIN 3647.
453 KIN 4506 and 4507.
454 KIN 4507.
455 KIN 4513 and 4514.

628 In his statement to the Inquiry Mr Smyth accepted that he did not have, and does not have, evidence for his propositions that McGrath was an agent of the state and that Kincora involved an operation run by the Intelligence Agencies, and that he speculated because there had been years of speculation about Kincora by others, and the allegations had been largely met by silence from the authorities.[456]

Allegations about other British Officials in the Northern Ireland Office

629 In early 1982 the then Political Correspondent of the BBC in Northern Ireland, the late W (Billy) D Flackes told Mr David Gilliland, who was the Director of Information Services for the Northern Ireland Office, that four former officials of the NIO had been concerned in homosexual activity, three of whom were believed to have been involved in homosexual offences against children. Mr Gilliland later told the police that Mr Flackes named the four officials as Peter England, Brian Watkins, Leslie Imrie and Peter Bell. It was also alleged to Mr Gilliland that the person who later became Sir Maurice Oldfield's private secretary had been the subject of an attempted indecent assault by Peter England.

630 Mr Flackes was interviewed by D/Supt Caskey on 6 April 1982 about these allegations. He declined to make a written statement, but said that the information concerning the four officials was common gossip and had been for years. Mr Flackes said he had no knowledge of any criminal acts, and nothing to indicate a vice or prostitution ring.

631 Mr Hewitt who was Sir Maurice Oldfield's private secretary while Sir Maurice was Security Coordinator in Northern Ireland, told the police that he had never been assaulted by Mr England.[457] Mr England died on 24 August 1978. Mr Bell was interviewed by D/Supt Caskey on 7 April 1982. He denied the allegations relating to him.[458] Mr Imrie was interviewed on 26 April 1982 and provided a written statement dated 28 April 1982. He also denied the allegations and denied that he was homosexual. He referred to a report in *Private Eye* relating to his conviction in April 1979 for masturbating in a public place in London, saying that he denied the allegation and felt the outcome was unjust.

456 KIN 4506.
457 KIN 1986.
458 KIN 1983.

He denied that he was homosexual, or having homosexual relationships while he was in Northern Ireland in 1972/1973.[459]

632 Mr Flackes said these allegations were common gossip and had been circulating among journalists and others for years.[460] The Inquiry has found no evidence to support the allegations that these individuals were involved with homosexual activity connected in any way with Kincora residents.

633 During the process of examination by the Inquiry of other files after the conclusion of the public hearings, Inquiry Counsel raised a number of issues with MI5, and their response to these issues was contained in a further witness statement by Witness 9004 dated 29 November 2016. We do not consider it necessary to refer to each of the matters raised therein; they can be seen in the statement which can be found at KIN 4135 and following.

Reference by SIS Officer to an Agent 'aware of sexual malpractice'

634 A reference by SIS Officer A in his witness statement of 27 May 2016 to "at least one agent who was aware of sexual malpractice at [Kincora] and who may have mentioned this to his SIS or Security Service Case officer" prompted Officer 9004 to deal with this. A Note for File dated 17 October 1989 which was written by MI5 Officer 1 contained a record of the meeting with the SIS Officer concerned. That note refers to a particular CHIS whose identity is known to the Inquiry. MI5 Officer 1 expressed a view in that record that some of the information on the CHIS's file could be "incorrectly interpreted".[461]

635 In paragraph 9 of his witness statement Officer 9004 concluded:

> "Extensive reviews of its files enables MI5 to confirm that no MI5 CHIS produced intelligence about child abuse at Kincora prior to the media revelations of January 1980."[462]

459 KIN 1993.
460 KIN 1982.
461 KIN 4136.
462 KIN 4136.

Reference by ADCI to 'false files' in 1982

636 In a telex sent on 29/30 June 1982 by the MI5 Assistant Director and Coordinator of Intelligence (ADCI) he referred to the possibility of creating "false files" in anticipation of lines of enquiry which it was anticipated D/Supt Caskey would seek to follow in his Caskey Phase Three investigation into Kincora.[463] The use of the expression "false files" demonstrates that a senior MI5 officer considered the possibility of creating a "false", that is a misleading or untrue, file to show to the police. This reference could be interpreted to mean either (a) that such a file would be composed of fabricated documents, or (b) that genuine documents would be brought together from other files but placed in a single file in a manner that would conceal sensitive material. Whichever was in the officer's mind when he used the expression, the use of the expression "false files" was at best unwise and at worst demonstrated a willingness to deceive the police.

637 The relevant portion of the telex relates to whether MI5 should disclose the identity of one of its agents to D/Supt Caskey because MI5 had not told the RUC Special Branch that the person was an MI5 source. The MI5 officer's telex continued:

> "We will also ask HSB [Head of Special Branch]/DHSB [Deputy Head of Special Branch] about the status of this particular enquiry and what is likely to happen to any report that is produced. We assume Caskey is an astute police officer and we should be in difficulty if we attempt to deceive him and manufacture false files or deny the existence of real ones."[464]

638 The context of the telex makes it clear that the idea was only raised to be discarded by the officer concerned, and we are satisfied the suggestion was not pursued in this instance.

463 KIN 4182.
464 KIN 4182.

APPENDIX 1: List of Search Terms circulated by NIO, 18 November 2014

Search terms notified by the NIO, after consultation with the Inquiry, to HMG Departments and Agencies in Sir Jonathan Stephens's letter of 18 November 2014. Some Departments and Agencies augmented this list with additional search terms and variant spellings (the reference to "Valetta" below is to the Valetta Park Hostel in Newtownards, County Down).

Bawnmore

Bernardos, Ravelston Parade

Boy's Home and Northern Ireland

Brian Gemmell

Child abuse and Northern Ireland

Children's Homes and Northern Ireland

Colin Wallace

Hughes/Hughes Inquiry

Institutional abuse

Joseph Mains

Richard Kerr

Kincora

Kincora Boys' home

Kincora Boys' home inquiry

Mike Taylor

Nazareth Lodge

Palmerston

Rathgael

Raymond Semple

Rubane Boys' Home (in the context of which a James McGuigan was charged with criminal offences)

Tara

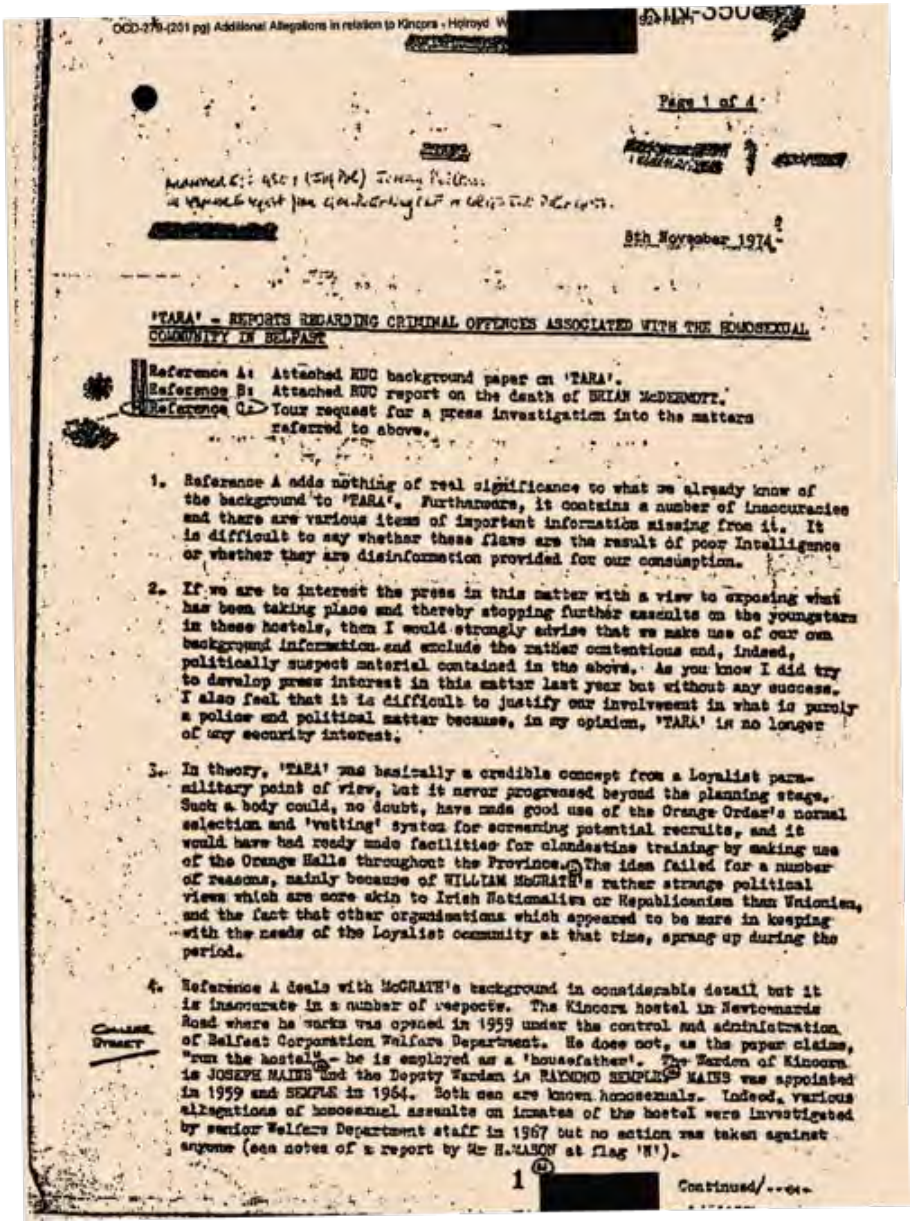
Valetta

William McGrath

Williamson House

Manor House, Lisburn

APPENDIX 2: Memorandum dated 8 November 1974 / GC80 Document



OCD-279-(201 pg) Additional Allegations in relation to Kincora - Holroyd W [redacted]

Page 1 of 4

[redacted]

8th November 1974

'TARA' - REPORTS REGARDING CRIMINAL OFFENCES ASSOCIATED WITH THE HOMOSEXUAL COMMUNITY IN BELFAST

Reference A: Attached RUC background paper on 'TARA'.
Reference B: Attached RUC report on the death of BRIAN McDERMOTT.
Reference C: Your request for a press investigation into the matters referred to above.

1. Reference A adds nothing of real significance to what we already know of the background to 'TARA'. Furthermore, it contains a number of inaccuracies and there are various items of important information missing from it. It is difficult to say whether these flaws are the result of poor Intelligence or whether they are disinformation provided for our consumption.

2. If we are to interest the press in this matter with a view to exposing what has been taking place and thereby stopping further assaults on the youngsters in these hostels, then I would strongly advise that we make use of our own background information and exclude the rather contentious and, indeed, politically suspect material contained in the above. As you know I did try to develop press interest in this matter last year but without any success. I also feel that it is difficult to justify our involvement in what is purely a police and political matter because, in my opinion, 'TARA' is no longer of any security interest.

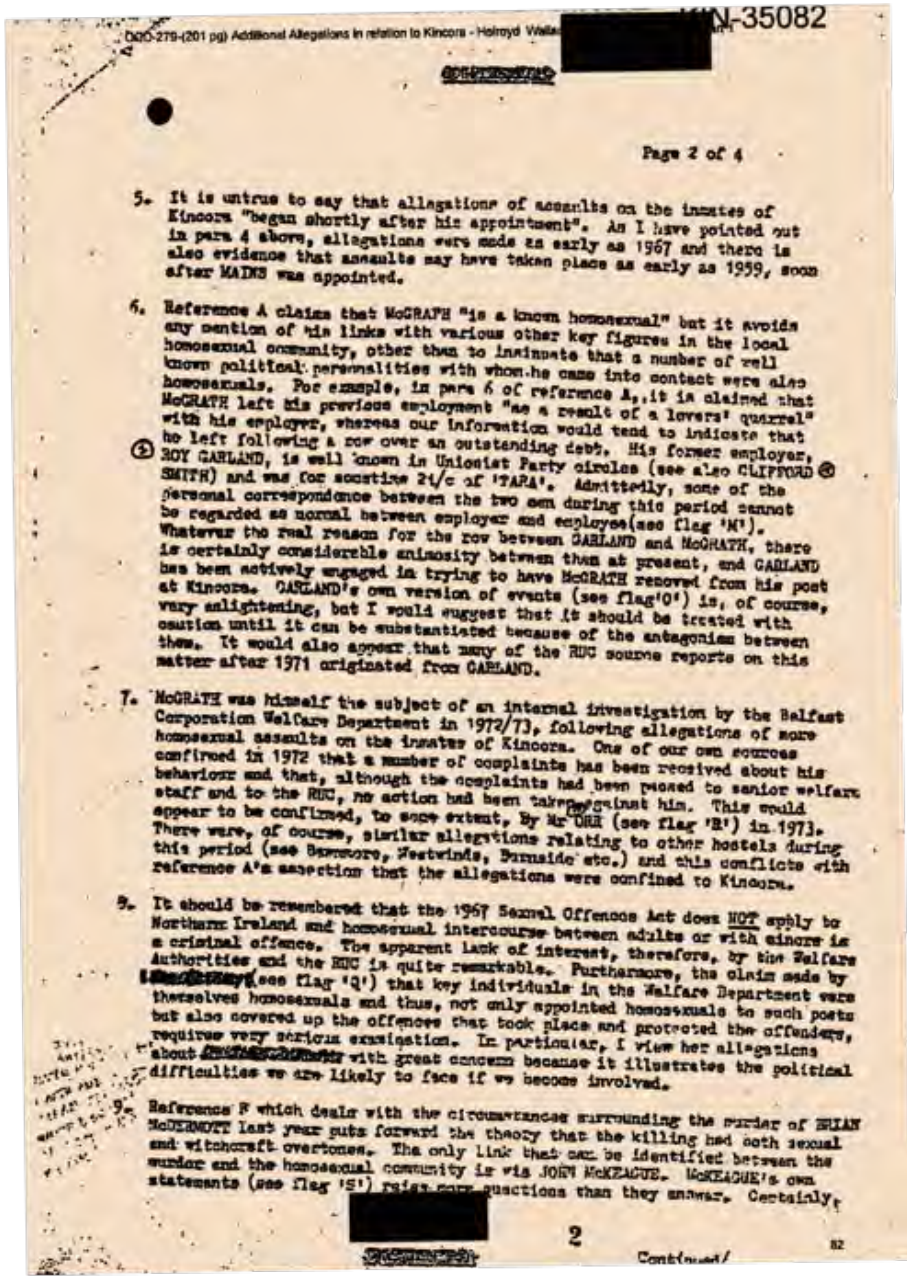
3. In theory, 'TARA' was basically a credible concept from a Loyalist para-military point of view, but it never progressed beyond the planning stage. Such a body could, no doubt, have made good use of the Orange Order's normal selection and 'vetting' system for screening potential recruits, and it would have had ready made facilities for clandestine training by making use of the Orange Halls throughout the Province. The idea failed for a number of reasons, mainly because of WILLIAM McGRATH's rather strange political views which are more akin to Irish Nationalism or Republicanism than Unionism, and the fact that other organisations which appeared to be more in keeping with the needs of the Loyalist community at that time, sprang up during the period.

4. Reference A deals with McGRATH's background in considerable detail but it is inaccurate in a number of respects. The Kincora hostel in Newtownards Road where he works was opened in 1959 under the control and administration of Belfast Corporation Welfare Department. He does not, as the paper claims, "run the hostel" - he is employed as a 'housefather'. The Warden of Kincora is JOSEPH MAINS and the Deputy Warden is RAYMOND SEMPLE. MAINS was appointed in 1959 and SEMPLE in 1964. Both men are known homosexuals. Indeed, various allegations of homosexual assaults on inmates of the hostel were investigated by senior Welfare Department staff in 1967 but no action was taken against anyone (see notes of a report by Mr H.MASON at flag 'H').

College Street

1 [redacted]

Continued/...



DOD-279-(201 pg) Additional Allegations in relation to Kincora - Holroyd Walla[redacted] KIN-35082

[redacted]

Page 2 of 4

5. It is untrue to say that allegations of assaults on the inmates of Kincora "began shortly after his appointment". As I have pointed out in para 4 above, allegations were made as early as 1967 and there is also evidence that assaults may have taken place as early as 1959, soon after MAINS was appointed.

6. Reference A claims that McGRATH "is a known homosexual" but it avoids any mention of his links with various other key figures in the local homosexual community, other than to insinuate that a number of well known political personalities with whom he came into contact were also homosexuals. For example, in para 6 of reference A, it is claimed that McGRATH left his previous employment "as a result of a lovers' quarrel" with his employer, whereas our information would tend to indicate that he left following a row over an outstanding debt. His former employer, ROY GARLAND, is well known in Unionist Party circles (see also CLIFFORD SMITH) and was for sometime P/C of 'TARA'. Admittedly, some of the personal correspondence between the two men during this period cannot be regarded as normal between employer and employee(see flag 'M'). Whatever the real reason for the row between GARLAND and McGRATH, there is certainly considerable animosity between them at present, and GARLAND has been actively engaged in trying to have McGRATH removed from his post at Kincora. GARLAND's own version of events (see flag'O') is, of course, very enlightening, but I would suggest that it should be treated with caution until it can be substantiated because of the antagonism between them. It would also appear that many of the RUC source reports on this matter after 1971 originated from GARLAND.

7. McGRATH was himself the subject of an internal investigation by the Belfast Corporation Welfare Department in 1972/73, following allegations of more homosexual assaults on the inmates of Kincora. One of our own sources confirmed in 1972 that a number of complaints has been passed to senior welfare staff and to the RUC, no action had been taken against him. This would appear to be confirmed, to some extent, by Mr ORR (see flag 'R') in 1973. There were, of course, similar allegations relating to other hostels during this period (see Bannoore, Westwinds, Barnside etc.) and this conflicts with reference A's assertion that the allegations were confined to Kincora.

8. It should be remembered that the 1967 Sexual Offences Act does NOT apply to Northern Ireland and homosexual intercourse between adults or with Kincora is a criminal offence. The apparent lack of interest, therefore, by the Welfare Authorities and the RUC is quite remarkable. Furthermore, the claim made by [redacted](see flag 'Q') that key individuals in the Welfare Department were themselves homosexuals and thus, not only appointed homosexuals to such posts but also covered up the offences that took place and protected the offenders, requires very serious examination. In particular, I view her allegations about [redacted] with great concern because it illustrates the political difficulties we are likely to face if we become involved.

9. Reference F which deals with the circumstances surrounding the murder of BRIAN McDERMOTT last year puts forward the theory that the killing had both sexual and witchcraft overtones. The only link that can be identified between the murder and the homosexual community is via JOHN McKEAGUE. McKEAGUE's own statements (see flag 'S') raise more questions than they answer. Certainly,

[redacted]

2

Continued/

82

[redacted]

9. continued..

his boast that he will not be prosecuted because "he knows too much about some people" merits serious investigation, but I suspect that he will no be prepared to talk until he is released. It is also rather remarkable that no charges have be preferred against him, at least during the past 3-4 years. Our own investigations of instances of alleged witchcraft or other satanic rites in the Province would tend to dismiss the RUC's theory that BRIAN McDERMOTT's murder could be part of these activities. In the past, 'Black Magic' practices etc have been mainly confined to groups operating from Republican areas, with the possible exception of three cases in Co Antrim. I think, however, that from a press point of view, we would be very foolish to give any credence to such claims without the most convincing evidence. The forensic reports on the McDERMOTT murder (see flag 'F') would tend to indicate that someone tried to dispose of the body by cutting it into pieces and burning them. It would also appear that when this failed, the pieces were dumped in the river. The insinuation made in the document regarding the boy's disappearance and the proximity of the Rev PAISLEY's church is dangerous nonsense.

10. Reference A claims that a number of key personalities in the political arena "are aware of" the Kincora situation and, in particular, of McGRATH's background. It does not, however, explain the extent of their awareness nor of each individual's involvement with McGRATH. In summary, it would appear that the document is claiming that:-

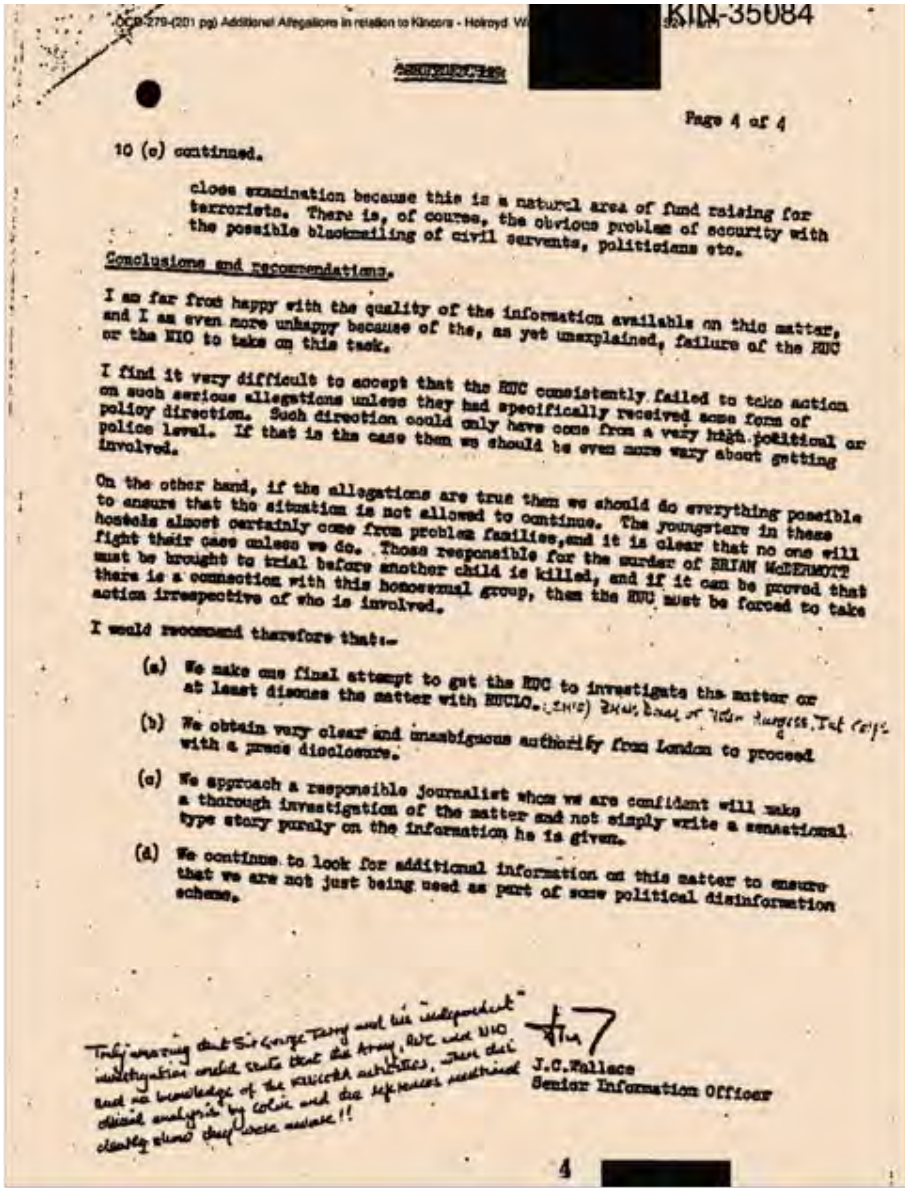
(a) Senior members of the Grand Orange Lodge are aware of the situation because of the discussions and correspondence relating to McGRATH within the Orange Order (see flag 'C'). It is further alleged that THOMAS PASSMORE and the Rev MARTIN SMYTH have blocked any action against McGRATH.

(b) The Rev PAISLEY is aware of the situation but has failed to take any action because of possible blackmail pressure owing to his connection with McGRATH, DAVID BROWN and JOHN McKEAGUE. On the face of it, the statements made by VALERIE SHAW and TOM McNEILLY (see flag 'F') would tend to support the only part of such a claim. There are also a number of inconsistencies: McGRATH would appear to be strongly anti-communist and anti-U.V.F and this conflicts with the document's views on links with TOMMY HERRON, ERSKINE 'DUKE' ELLIOTT, 'The Ulster Citizens Army' etc.

(c) Various public and political figures who hold positions of power and who are also homosexual protect each other from prosecution. The claim of a prostitution ring involving juveniles and centered on Bangor is not really substantiated, other than by GARLAND's own personal account. It would be interesting to check, however, the number of charges brought against people involved in homosexual activities in the greater Belfast area in the last 5 years. I also think that the RUC report on drug abuse in this connection merits

[redacted]

Continued/.....



OCB 279-(201 pg) Additional Allegations in relation to Kincora - Holroyd Wi [redacted] KIN-35084

[redacted]

Page 4 of 4

10 (c) continued.

close examination because this is a natural area of fund raising for terrorists. There is, of course, the obvious problem of security with the possible blackmailing of civil servants, politicians etc.

Conclusions and recommendations.

I am far from happy with the quality of the information available on this matter, and I am even more unhappy because of the, as yet unexplained, failure of the RUC or the NIO to take on this task.

I find it very difficult to accept that the RUC consistently failed to take action on such serious allegations unless they had specifically received some form of policy direction. Such direction could only have come from a very high political or police level. If that is the case then we should be even more wary about getting involved.

On the other hand, if the allegations are true then we should do everything possible to ensure that the situation is not allowed to continue. The youngsters in these hostels almost certainly come from problem families, and it is clear that no one will fight their case unless we do. Those responsible for the murder of BRIAN McERLAOTT must be brought to trial before another child is killed, and if it can be proved that there is a connection with this homosexual group, then the RUC must be forced to take action irrespective of who is involved.

I would recommend therefore that:-

(a) We make one final attempt to get the RUC to investigate the matter or at least discuss the matter with RUCLO. (NIO) [illegible]

(b) We obtain very clear and unambiguous authority from London to proceed with a press disclosure.

(c) We approach a responsible journalist whom we are confident will make a thorough investigation of the matter and not simply write a sensational type story purely on the information he is given.

(d) We continue to look for additional information on this matter to ensure that we are not just being used as part of some political disinformation scheme.

Today hearing that Sir George Terry and his "independent" investigation ended [illegible] that the Army, RUC and NIO had no knowledge of the security authorities, their [illegible] analysis by Colin and the inferences [illegible] clearly showed they were aware!!

J.C. Wallace
Senior Information Officer

4 [redacted]

APPENDIX 3: Transcript of interview with Major General Peter Leng by Barrie Penrose for *Sunday Times* article published on 18 February 1990

KIN - 124556

① 9 27

CATCH:TRAN62 VER:01 BY:JEN :19/02,12:14 OPR:TAGART,22/02,12:15
FG:stl DIR: PG: PDATE: LBR: MR:1
MEMO: FR:HOM19 ,20/02,18:01 STYL:
KEY: M3: 08137 WDR GR:TAGART-HWF

FIRST CONVERSATION WITH PETER LENG

PENROSE: I am doing a piece for the weekend and I was going to suggest that as I mention you just in passing, it might be courteous to read it over to you on Friday. It's only a passing mention. I tell you what it is actually. We are still Wallacing, so to speak, and on that front we mention that Michael Taylor, you probably wouldn't remember him. He has been mentioned in the press just briefly, he was information officer, and he has told me that he remembers very well indeed, and he was delighted when he saw it, that on the Kincora file that he was looking after he says that you had a strong memo saying there has got to be some action on this or something to that effect, and he said that he remembered thinking well, we'll just wait for this to happen, it was obviously going to happen quite soon but it didn't. Now this was back in 74 and your memo was actually attached to the file. And his surprise was, along with a couple of colleagues that nothing did happen and he could only think that the RUC were taking their time, and of course as we all know now its a matter of two reports since then, the Terry one and Judge Hughes, but of course nothing did happen until 1980. So basically it was just a passing reference to your memo being attached to the file.

LENG: OK.

PENROSE: So you're not obviously disagreeing about that. The other thing is did you by any chance see Paul Foot's book?

LENG: No.

PENROSE: Would you like me to send you a copy?

LENG: Yes and I'll pay you for it.

PENROSE: No, no, that's easily arranged because I have got two copies. Now the thing is that the paperback I'm told by the publishers is not out until March but the hardback copy, it does actually mention you. And if I may I'll just read ... I was just looking at it this morning, it's on page 39, but as I say I will send you the whole book but it says here – this is the mention of Clockwork Orange, which as you know is now being mentioned in the House of Commons ...

LENG: I have been away for 2 weeks, so I got only just got back two days ago, so I have missed it all you see.

PENROSE: Well I won't be in the office until tomorrow but what I will do (inaud)

KIN - 124557

(2) 1 27

MATCH: THANKS PAGE 2

is photocopy undecipherable couple of words from Leng - could be page 27 or 27... not only that, but I'll put that in the post to you, but also page 29 and also there are a couple of other things that will bring you right up to date - Let me just tell you very briefly. Peter Broderick, whose name you may recall, who was Taylor and Wallace's boss along with other people, now he came up while you were away, so this would be about 10 days ago, he came out and said he well remembers the matters of that time, so does Taylor, and they mention Clockwork Orange and in the House of Commons both Archie Hamilton and Tom King have mentioned Clockwork Orange saying that papers have been found showing that in fact it was, unfortunately, that the House had been misled, no fault of Tom King or Archie Hamilton, simply, the records had simply come to light more recently. So you probably may have picked that up already, had you or not?

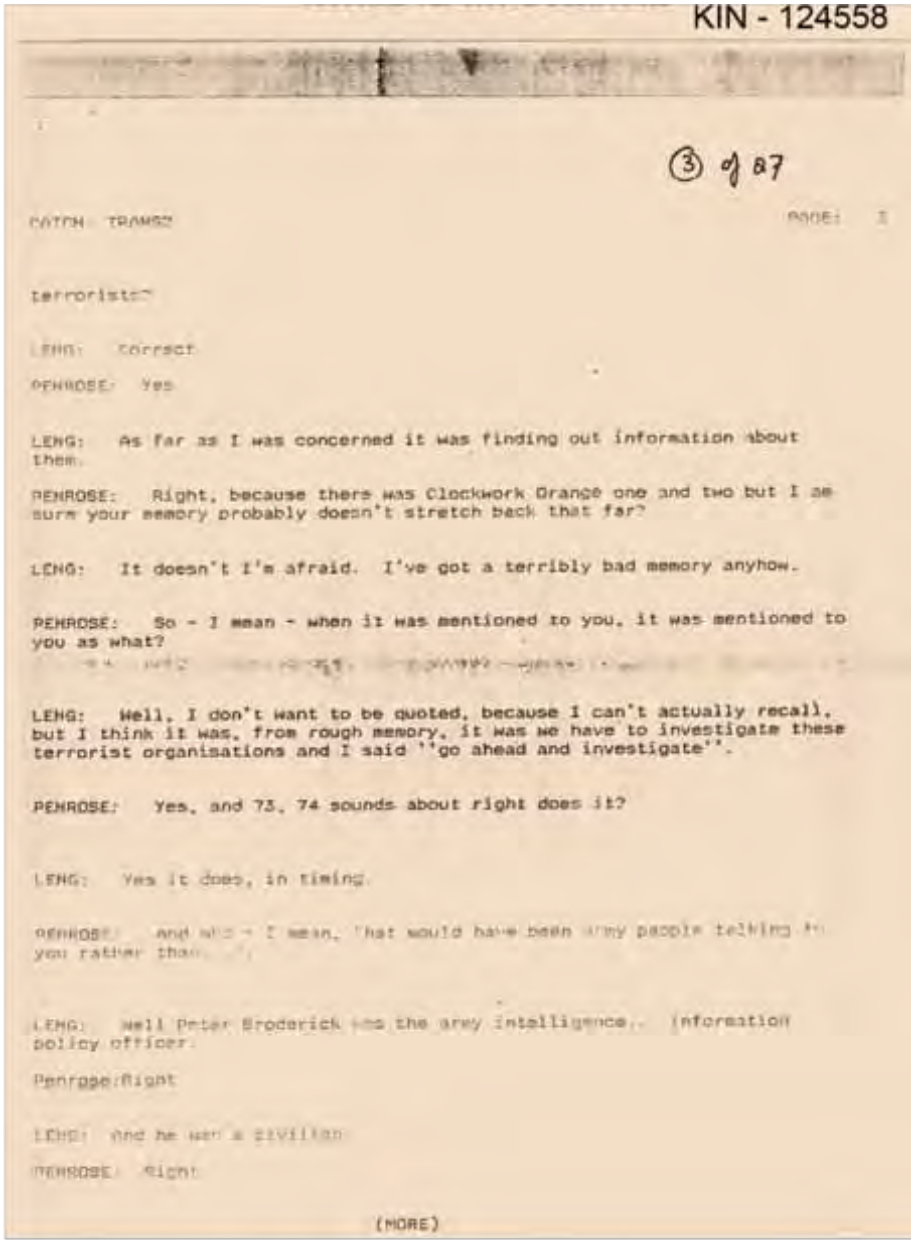
LENG: No.

PENROSE: No, you didn't. Well that is the present state of play. Now it says here on page 28 of Foot's book - the documents which were filed under Clockwork Orange were not personally available to anyone else in the information policy department. A fact which Mike Taylor, an army information officer, recalls very clearly. And then he said, well he has actually said to me as well, that he was looking after Clockwork Orange and what it contained. He then goes on to say, and this is where you are mentioned. It says here, ''the army's involvement in Clockwork Orange was approved early in 74 by the Commander of Land Forces Northern Ireland, Major General Peter Leng. Col. Peter Goss, the senior army intelligence officer at Lisburn, was instructed to release to Colin Wallace secret information on terrorists. Captain ..'' and he mentions another Captain here, another intelligence officer was appointed to do the basic research and supply Wallace with the results. And it goes on to say that this was disinformation about paramilitary groups. Then in fact it went wider and included some material about politicians, some of them in Northern Ireland, some of them on the mainland. So, I don't know whether you recall the Clockwork Orange...

LENG: Well, I hardly recall it, and certainly I had no party sic at all in anything to do with politicians and nor would I. I mean my policy at that particular stage was that we had to play the game straight. We had to find out... we obviously had to do some research into terrorists but there was to be no dirty games at all so far as I was concerned, and one or two people, and I can't recall who came up and said to me we'd like to do this, and my answer was always no. The army has got to be played clean because these things get found out in time.

PENROSE: Yes, well that's what I was told. It was not only about your role, such as it was, but also Frank King's as well, he also said the same thing. I mean the thing is I mean the Clockwork Orange operation as you recall it, if I understand you correctly, was directed against

(MORE)



KIN - 124558

③ of 87

PATH: TRANS2 PAGE: 1

terrorists?

LENG: Correct

PENROSE: Yes

LENG: As far as I was concerned it was finding out information about them.

PENROSE: Right, because there was Clockwork Orange one and two but I am sure your memory probably doesn't stretch back that far?

LENG: It doesn't I'm afraid. I've got a terribly bad memory anyhow.

PENROSE: So - I mean - when it was mentioned to you, it was mentioned to you as what?

LENG: Well, I don't want to be quoted, because I can't actually recall, but I think it was, from rough memory, it was we have to investigate these terrorist organisations and I said ''go ahead and investigate''.

PENROSE: Yes, and 73, 74 sounds about right does it?

LENG: Yes it does, in timing.

PENROSE: And who - I mean, that would have been [illegible] people talking to you rather than [illegible]?

LENG: Well Peter Broderick was the army intelligence, information policy officer.

Penrose:Right

LENG: And he was a civilian

PENROSE: Right

(MORE)

KIN - 124559

④ of 27

PATH: TRANS2 PAGE: 4

LENG: And the rest of them were army.

PENROSE: Yes. And Colin Wallace you would have known?

LENG: Well hardly. I mean known yes, but as he was a captain working right down the chain.

PENROSE: Yes

LENG: I didn't. I mean I hardly came across him at all.

PENROSE: Because everyone, including Broderick, I must say, they speak so highly ... and so do the records of him at the time, that he was hard working and so on, but that's something that obviously ... you were at a level where you wouldn't have come across him very much.

LENG: Correct.

PENROSE: But it wouldn't surprise you that he was involved along with Broderick and the others and Taylor.....

LENG: If he was working under Broderick he would be involved.

PENROSE: With Clockwork Orange, Yes. And how many people would have known about Clockwork Orange? Would it I'm just wondering.

LENG: Well I think that the senior intelligence officer would have known, Broderick would have known, Mike Garrett.

PENROSE: Yes, I remember that name.

LENG: ... who I'm afraid is very ill with leukaemia now, he would be more involved than the chief of staff, and how what I would be doing is to listen to the policy.

PENROSE: How long would an operation like that have lasted?

(MORE)

KIN - 124560

⑤ g 27

PAGE: 5

LENG: Well, as long as it takes to gather the information. It could have lasted, and this is entire guess work, a month, three months, six months, a year because it takes an awful lot of time to gather intelligence.

PENROSE: When you mentioned earlier that when anyone suggested to you that, and this is my word not yours, can we get into the black propaganda or dirty tricks and you said "No", that was when politicians were mentioned presumably?

LENG: Politicians were never mentioned to me...

PENROSE: To you.

LENG: ... I mean I have no recollection and no knowledge at all of the involvement of politicians, and the investigation of politicians, and certainly, had I known about it I would have stopped it at once. It is not our business.

PENROSE: Yes. You see what Wallace and Taylor say is that they were in a difficult position because from one side they were being told by the army and by you and your senior staff officers and saying absolutely play it clean and down the middle, and 100% on that, they then say that unfortunately the funnies as they call them, in other words MI5, were saying sometimes, well look you've got to relegate this or do this without anyone else knowing because ...

LENG: Well ... we ... I ... other than an initial briefing by MI5 and no-one before I took on my appointment, I had no contact with MI5 thereafter.

PENROSE: No. So you wouldn't have known that they had another interesting Clockwork Orange? That would have been outside you knowledge?

LENG: Completely outside.

PENROSE: Yes.

(MORE)

KIN - 124561

6 of 37

CATCH: TRANS2 PAGE: 1

LENG: Completely, and I suspect outside Frank King's jurisdiction too.

PENROSE: Absolutely. That's absolutely right from our ... yes, I mean, that's the case. Presumably you wouldn't have actually yourself looked at Clockwork Orange as a file itself? So therefore ..

LENG: I never saw the file of Clockwork Orange whatsoever.

PENROSE: Well I think your hair would have fallen out if you had. And you would have stopped it of course then...?

LENG: Well had I known - I mean any involvement I would have stopped it...I had one or two people who came up and suggested one or two things and I turned them down flat, every single time.

PENROSE: What sort of things? ..Just to give me an idea of what sort of...

LENG: Are we off the record?

PENROSE: Oh Yes!! We are now!!!!

LENG: Well I remember a case where they wanted to go and publish a diary - it was written by IRA people

PENROSE: Mm

LENG: ... and they were then going to leak it to the press...

PENROSE: Right.

LENG: ... for a sum of money to make it look authentic.

PENROSE: Mm.

LENG: And I think they did quite a lot of preparation for this, and then they came to me and said look we would like to do this because it would

(MORE)

KIN - 124562

⑦ of 27

BATCH: TRANCE PAGE: 7

give quite a lot of evidence and would also cause the IRA perhaps to squeak. My answer as you can imagine was this is absolutely impossible to do - we are bound to be found out - stop it now.

PENROSE: Yes, otherwise it will rebound. You see on the other hand, the interesting thing is that it was never mentioned to you obviously by the people that they wanted to extend to politicians and in fact did so.

LENG: No, never.

PENROSE: Did you know there was a Clockwork Orange one and two?

LENG: Really?

PENROSE: No. And on Kincora you come out absolutely as one would expect, saying there has got to be action on Kincora. Do you recall that?

LENG: No.

PENROSE: Well, you should take your virtue because in fact Taylor says, I remember it very well and we were all delighted that the RUC were... you said in the memo according to Taylor that the RUC and the social services I think ought to be brought in here because the file named men and boys who were obviously part of this abuse which we all know about now.

LENG: Yes I recall that.

PENROSE: Do you? And you said take action. They waited because obviously there had been other members suggesting this from junior offices, but it was yours that finally convinced Taylor that this was going to happen, but of course it went on for another six or seven years, but again that wasn't your fault.

LENG: I think the action, now I recall it, was the absconding of boys, and if I've got the thing right, there were an awful lot of what I call

(MORE)

KIN - 124563

⑧ of 27

CATCH: TRANS2 PAGE: 8

... well I'll call them terrorist boys who were put away in the home, and they kept on absconding, and I do remember talking to the chief of staff, saying "look we've got to stop these boys escaping from this remand home and there is far too much escaping and they are going back into terrorism, so take action to stop that."

PENROSE: It was also just to remind you that there were homosexual abuses taking place, namely by the house father says McGraph...

LENG: Yes.

PENROSE: ... who was also the leader of TARA, and of course eventually that was all proven in court some years afterwards, and also a man called McKay, but I man this is obviously outside....

LENG: Yes I do remember the homosexual insinuations and I do remember saying this is a police business, not ours.

PENROSE: Yes, because you probably know that since then, the suggestions have been that MI5 or others, not the army but others, were in fact using, obviously, a blackmail hold on people like McGraph which he has since confirmed, I mean that is a matter of record now, that he was blackmailed into working for intelligence to inform and so on, so you can see the tug of war that was taking place from your side, saying police, social services take action, and the other side saying no, we need the information..

LENG: But of course, I wasn't part of the other side.

PENROSE: No, quite. We'll leave, I'll get this to the post...indecipherably few words. May I leave a number at the office so you know who you're speaking to. Its 01

LENG: Just wait one moment, I'll have to nip next door, I've just come in from the garden will you hold on?

PENROSE: Right - 01 782 5648 and my name is Penrose and it's Barry Penrose, P-E-N-R-O-S-E.

LENG: Right, Barrie, thank you very much.

(MORE)

KIN - 124564

9 of 27

PATCH: TRANS2 PAGE: 9

PENROSE: And I'll pop that in the post so you'll get it Friday.

LENG: That's sweet of you.

PENROSE: Alright.

LENG: Thank you.

PENROSE: Goodbye.

LENG: Goodbye.
163

Follows Conversation with Sir Frank King 163-302
PLEASE NOTE THIS HAS NOT BEEN CHECKED AGAINST THE TAPE AS YET.
INTERVIEW WITH FRANK KING.

PENROSE: I'm doing a piece for the weekend Sunday Times on a subject that no doubt you have seen in the papers in recent weeks on the Colin Wallace affair. I just wanted to check with you, and you will understand why - there is a book called Who Framed Colin Wallace by Paul Foot.

KING: I haven't read it. I'll pay my library 32p and try and get a free copy.

PENROSE: I am sending one to a colleague of yours, Peter Long. I may as well order 2 from our library and pop one in the post for you. The paper back is out next month - I was told that by the publishers. The thing is in the book he is talking about Wallace and his problems in the early stages of '75 and everyone we have spoken to speaks very highly of his abilities when he was in Lisbon, and then you're mentioned on page 110 just in passing but I thought I ought to check it with you. Wallace says his problems with Clockwork Orange and raising the whole business about the boys home in Belfast - the Kincora business - it says - when he returned to Northern Ireland on Monday 27th January 1975 he voiced some of his fears to the general officer commanding Northern Ireland Sir Frank King.

KING: Well he never did. I don't think I've ever met him quite honestly. I am getting old now - I am 71 and I've got a very bad memory. I've been reading all this in the press with great interest and I don't recognise his face. I'm pretty sure I did meet him but he was a very junior chap in my headquarters. We had various press - I remember when I arrived the PR
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people had a great reception for the press really to meet the new GOC and obviously Wallace would have been there but I don't quite honestly remember his face. The peculiar situation in Northern Ireland in that when General Tuzo (sorry can't quite make that name out) was there he had to governments to deal with he had the Stormont(Sorry another name I can't make out -bad quality recording) government and the Westminster government so he demanded a CLF which he got to command all the troops and the chief of staff ran the headquarters, and when I got there the security problems were still at their height so I had a lot to do with the secretary of state, I had a lot to do with the police because I was director of operations, but I had very little to do with my own headquarters. Three days a week I was going round the province... I cannot in all honesty, ever remember meeting Clive Wallace, Colin Wallace, having said that, I probably did.

PENROSE: There are, not that that proves anything, but there are ordinary army photographs taken at the time and issued to the press where Colin Wallace is in the picture along with two or three other people but one would expect that with an information officer. When I spoke to Sir Peter, he confirms two things - firstly he recalls Clockwork Orange, and says, look I told people who wanted to play about with dirty tricks, leave it alone, it will all go wrong, blow up in our faces, I want nothing to do with it. That was on Clockwork Orange. Is that something that you recall at all?

KING: I am being absolutely honest - I can never remember hearing that phrase before.

PENROSE: No, because as you know in the comsons Tom King and indeed Archie Hamilton have said that they have now found mention of it in the files that have only just surfaced, so there is nothing secret about it.

KING: I find it very difficult to understand in fact because, I mean its all being blamed on the security force

PENROSE: Security services, Yes.

KING: And I only had to the best of my memory of 15 years, I only had one man, and I knew exactly how he was tasked and he was a very sensible and a very good man, and he wasn't tasked on anything like that.

PENROSE: Or the other matter of McGrath and TARA and that hasty burial of Kincora, you don't recall anything of that?

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KING: I remember seeing it in the Belfast Telegraph as a scandal in Northern Ireland.

PENROSE: That would have been 1980?

KING: Was it.....yes.

PENROSE: Because a chap, again he was far too junior, but an army information officer, Michael Taylor, he, amongst his duties was to look after various files including Clockwork Orange and Kincora and he recalls that General Leng had put a memo as had other people, around about 73, 74, saying must bring in the RUC and the social services into Kincora because is a scandal and this must stop. I mean, this was about homosexual abuses and people running away.....

KING: Was that the place where young men had been locked up?

PENROSE: No this was a young boys home and the suggestion has been, the point being that General Leng and others had said in memos on the Kincora file at Lisbon that there must be action here, and urgent and so on, but of course, nothing happened until 1980

KING: Why does this concern the army?

PENROSE: Well because the internal memos that intelligence people had used knowledge of homosexual abuses between people like McGraph who was the paramilitary leader of TARA, that MI5 had actually had information about McGraph and homosexual abuses and this would prove very useful because McGraph had obviously given information about TARA and loyalist paramilitary groups - so you see the point - they were saying there will [illegible] meanwhile the army were saying you have got to act, but this isn't something that you recall at all?

KING: No I don't quite honestly. One always realised that in the jungle of Ireland on both sides a lot of murky things happened, but quite honestly, I was far too busy in a sense at the higher level to know about those things.

PENROSE: Well, one thing that two or three people have said, and I remember their names quite well, having spoken to them for quite some time about this when your name just cropped up in passing.. Oh yes, I know, one of them was Peter Broderick.. Do you remember Peter Broderick?

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KING: He was my information policy officer

ROSROSE: That's right. How he said that he was brought over and the first thing you said to him when he arrived. this is a quote from Peter Broderick...None of this nonsense about black propaganda or dirty tricks or something to that effect.. is that anything that you...

KING: I don't remember but I can understand it. You see one of the problems that the army had, it had a very bad reputation with the press to begin with and the reason was that we were always reactive. One thing I remember very well where a unit went in to search a house and their side of the story was that they carried out army orders which were that they would always have a carpenter there so that if they had to take up floor boards or take a lintel out of a window he would repair the damage. But suddenly on BBC television I think the whole place was totally wrecked, and imagine the pressure when you get the secretary of state ringing up saying why have the army done this and the GOC ringing up the commanding officer and saying why have we done that, but we didn't. So we had a rule then that whenever they searched a house, they got a certificate signed by the householder that they left the house in good condition. But again, the IRA would put pressure on householders and they refused to sign, and the same sort of thing would happen again. And you get another case, lets take a soldier on patrol where he sees two men with a rifle and he shoots one, and the other chap picks up the armour and runs away and then all the neighbours come out hearing the shots and swear with tears streaming down their faces that this man was taking a quiet walk a night and was suddenly shot by a soldier and he wasn't armed and so on. So you get both sides taking sides. The IRA are very good at this because quite often one thing all commanding officers learn in Northern Ireland is that is there are television cameras in the street, don't send your soldiers up that street, because something is going to happen. They were very good at promoting these incidents, and by the same token, the only thing the army could do was to train its public relations people as well as it could, and we did run a school in Beconsfield to train people on television courses and so on, and have a nominated officer in each unit as a PR officer, and to use people like Broderick who were experts and professional at headquarters But we were always on the defensive because the IRA could always provoke incidents and have their press things ready, and the army quite often had to make an investigation, get in touch with the unit find out what happened and sometimes rather foolishly, issue a statement early and then find it was wrong and have to correct it later. So it was always a great problem.

ROSROSE: Yes, I can see that. Tell me, on the we have read about it and heard about it in Parliament recently in the last few days in fact, on the question of so called dirty tricks and black propaganda is that

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something.. after all SINOPSIS is an MOD leaflet or pamphlet, so again, there is nothing secret about that, is that something that would have crossed your desk at any time?

KING: Well I think basically that this is an invention of the press. I'm sorry to be rude about this but it's probably because we were always on the defensive and we quite often appeared to be telling lies, but one thing I'm quite sure all the PR people realise is that you can't feed off black propaganda unless it's based on truth because you lose your reputation with the press. But I think that this is how the thing blew up. Quite honestly there is only one thing I can remember while I was the OC - one of the elections there the IRA or Sinn Fein brought out a great poster for an election where they had a hooded monster with a rifle over his shoulder with the words underneath saying ''Victory by 1974''. Well we did the same sort of thing. We got hold of this poster and we did a bit of black propaganda but it was very harmless and rather humourous and we over printed the words ''By Ballot, Not By Bullet'' and we posted these up all over Belfast and took down the IRA ones and eventually, they reckoned that our posters were there posters. And quite honestly, that's the only thing I can remember.

PENROSE: Because the thing is that people like Wallace, and he is by no means alone, Broderick, and others as well, Michael Taylor, in that department, they seem to be saying, and I think I've got this absolutely right now, that the army are saying, at your level and obviously below your level, were saying look, black propaganda in a way against the IRA yes but not to go too far, but there were MI5 people who wanted to use it for a totally different purpose and that they widened it, and that's why we have had these allegations about smears against politicians, you know, the forgery, I mean the fact is at Lisbon....

KING: You may find this very difficult to believe, but to the best of my knowledge, I only had one chap, when I say to the best of my knowledge, I mean the best of my memory, I only had one chap working in my headquarters. He was a very nice reliable man. I knew exactly what his job was and he did it extraordinarily well. Now by the same token, there was another chap working under the secretary of state, or anyhow, under his control, what he did I never knew.

PENROSE: I think that was Clifford Brand.

KING: Well they were. There were about four chaps.

PENROSE: Are you talking about IRD people from the foreign office or the five people.

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KING: I think they were MI5 people. Rowley who had got a wooden leg, people like that. They in a way were the senior, that was the senior headquarters, and my press people went every week with the police press people to be briefed by Stormont's press officer, who laid down policy, which I presume was secretary of state policy, then so did the MI5 chaps.

PENROSE: Yes, this is where the rub seems to be, that a whatever level in MI5, it seems to be that they were attempting to move away from propaganda about the IRA, which is understandable, into the political area where for example, they expressed disagreements with Rees and Labour government policy, I suppose that is basically what.....

KING: I find this very difficult to believe. They basically wouldn't have time and really what is the point of it?

PENROSE: Well it does seem a little strange to me. I notice by the way, and you'll notice it when I send you the book by Foot on Wallace, that he quotes Reece's memoirs where he mentions.. shall I just read it.. its just a paragraph where you are mentioned. It says here - He wrote in his book, Northern Ireland, a Personal Perspective, this is Rees - I felt it important for my journey not to be publicised and asked Frank King, commander in chief of Northern Ireland forces to accompany me in my helicopter as far as Aldergrove, so it would look as if I was going back with him to Lisbon. However, when I arrived at Colerose, Cornwall, after a nostalgic flight over the valleys of south Wales where I was nurtured, it was to find that my trip had already been announced on BBC news. Was the leak from prying eyes at the castle or from Aldergrove or was it from other sources. - and it's really just Rees going on about what he claimed to be leaks from, I suppose he is talking about the security services not the army, but I mean we'll never know perhaps.

KING: I can never remember being in a helicopter with Merlin Rees in my life.

PENROSE: This is from his memoirs.

KING: Where was I flying in this helicopter.

PENROSE: You were flying .. Ah he doesn't say - it says - to accompany me in my helicopter as far as Aldergrove so it would look as if I was going back to Lisbon. So in other words you had set off from Lisbon it would seem, went to Aldergrove and then you were going back to Lisbon yourself. But anyway, that's just the two references. Well I'm very

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grateful for that and I'll get these books off in the post by the weekend.

KING: One thing that amused me in the press was Colin Wallace...I think Chris Ryder wrote an article... well anyhow...Colin Wallace claimed to have done three hundred parachute jumps. Well I have been a parachute soldier all my life and I can tell you the average number of jumps a parachute soldier does in a year is about six, so if he had been a parachute soldier, it would have taken him fifty years to do it. And then, in the same article, he said that he had been a member of a free-fall club, and the secretary there said he was a Roofer - he used to turn up in all the kit and nobody ever saw him go up.

PENROSE: Well in fact that has now been reversed. Records have been found where people have signed for.. I think... This is just a personal observation but one which people are making from both sides of the political divide and that is this - that many of the things that Wallace has said are now being confirmed by the government. For example, it was said that his 400 page document, file, had not been sent to number ten in 1985. Now Archie Hamilton said to the house last night that indeed that had been sent and it had been lost. So in other words, a lot of things that Wallace has been saying, now seem to be confirmed not just by his colleagues, but by the government saying that they are now delving deeper. But this is clearly something that was not in your orbit - it was in the intelligence orbit so it would seem, because it would seem that Wallace did have two hats as it were, two specific jobs.

KING: Well yes, one made use of all the intelligence one could get and he was a local man and to my knowledge, actively employed on intelligence. He was certainly a very Walter Mitty sort of chap. When I say that, I've already told you I never met him, I mean judging from what other people have said about him.

It [illegible] life interesting.

PENROSE: Well thank you very much.

End

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SECOND CONVERSATION WITH PETER LENG

000

PENROSE: Is Sir Peter there please, my name is Penrose, I spoke to him the other night

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PENROSE: I wonder if I could just clarify one thing so that I get it absolutely spot on. When something like Clockwork Orange (its such a silly name but anyway something like Clockwork Orange) comes on your desk and you say right go ahead and you must not go any further than this and this is what you must do, in this particular case gathering intelligence on para-military terrorists and so on. That would have come across presumably from HIO and from HIO go to your desk?

LENG: No, not necessarily. What it tended to do was to either go from intelligence to intelligence or from the northern sic office to Frank Kings office because, I put it crudely, he was a political general, and then I would get my marching orders from Frank King and really my role was just to carry out land operations, that is the day to day running of the army rather than get myself embroiled in that kind of work. Also it would be from intelligence quite often to special branch. Special branch and intelligence liaise together - the head of special branch of the RUC and the head of our intelligence and then I would have a morning meeting or maybe two or three daily meetings in which the head of intelligence would come up to me and say this is the sort of thing that is going on, and we would then discuss it.

PENROSE: The actual operation, I mean Clockwork Orange when it was first mooted was it Fort Dennis Paine - several people have mentioned that - who was at HIO

LENG: That's right, there was of course that branch as well. HIO would come in and pass forthings if they wanted to keep something from the RUC don't quote me again.

PENROSE: No, no no.

LENG: They would then - HIO would get straight in touch with our intelligence chiefs.

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PENROSE: Yes, so something like Clockwork Orange, or perhaps you remember - do you remember if it came from Paine's desk?

LENG: No I don't remember if it came from Paine's desk but certainly if it had gone anywhere it would have gone from intelligence to intelligence, from Nigels office across to our intelligence office...

PENROSE: I see - from - which office?

LENG: From Nigel's Office in the NIO it would have gone across - if he wanted to involve us at all he would have got on to our intelligence officer - that was the passage of information, and then .... I'm sure that was the way, and then if our intelligence officer wanted to bring in our publicity people, information policy as I call it, which let me say, I have to be absolutely clear, information policy is either white propaganda or black propaganda, and we have no part in black propaganda in our information policy at all.

PENROSE: Right.

LENG: So it was white propaganda.

PENROSE: How you said Nigel... is that Nigel....

LENG: Nigel Paine - do I mean that?

PENROSE: No Dennis Paine.

LENG: Dennis Paine at NIO.

PENROSE: Yes.

LENG: And it would cross there, and quite often I suspect they had conversations which I wasn't party to at all and I wouldn't object to that.

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PENROSE: No, of course. It's just to see how, if you could forgive me, how the bureaucracy works, so Clockwork Orange in this case comes from Dennis Paine's office, so it's intelligence to intelligence, and then you're shown it...

LENG: I'm not always shown it. Only if they need to involve someone at a higher level.

PENROSE: Right.

LENG: Now if it was policy, then Frank King would come into it, because he went to Northern Ireland Office weekly for a weekly conference with the police and all the rest of it, but he was quite often summoned across to speak to the Secretary of State or whoever, across there, and he it was who really did all the liaison policy work with the Northern Ireland office.

PENROSE: I see.

LENG: And then if there was anything - I mean, he often knew things that I didn' know, and then all he would do is say to me, this is the policy I want, and it was normally if I may say, tactical policy, and I would then follow it.

PENROSE: Clockwork orange was policy this sounds like a statement rather than a question, but a statement asking for confirmation...

LENG: And Clockwork Orange was policy.

PENROSE: Yes. And so - I see, so Dennis Paine sends the file over and this is policy from NIO...

LENG: I wouldn't have thought he would even send a file over if I may say so, because the less that was committed to paper the better...

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PENROSE: Oh, of course, I'm sorry, of course.

LENG: And I think there would be discussions because certainly intelligence and intelligence are meeting continually.

PENROSE: Yes, so ... fine, so it comes from there. Your job is of course, you have to OK Peter Goss, the senior intelligence officer, and Tony Holman and others, to release information to the unit, to the Information Policy Unit.

LENG: Yes, to the information policy unit or down to the units of the army...

PENROSE: Yes.

LENG: ... as the case may be.

PENROSE: Right. So you knew obviously that there was a five sic involvement in Clockwork Orange but you obviously wouldn't have known ...

LENG: ... the detail.

Penrose: the detail

LENG: Correct.

PENROSE: Right, and the other thingis that - which is obviously very important, is that as you didn't see the file that was kept at Lisburn, you wouldn't have known obviously its contents because there would have been no need for you to know.

LENG: Right.

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PENROSE: So you, as it were, authorise your people, Peter Goss and others to release information to the unit, to the information unit, so it's on your authority, or is it Frank Kings authority?

LENG: Oh we usually discussed that together, we usually had a - nothing worked so fast that it had to be dealt with, so we usually had a weekly conference and in fact often Peter Gough would go in to see Frank King about sensitive items direct and then he would see me

PENROSE: Ah - I see how it works.

LENG: ...about sensitive items.

PENROSE: So your...

LENG: My role with Peter Gough, if I may say so, was mainly running the straightforward tactical intelligence under his direction.

PENROSE: Yes.

LENG: I would, you know, we would discuss it and I would say right, that is what we want to tell the army and that is what the army ought to do.

PENROSE: Yes. I know you said your memory is sketchy sometimes on these things but the 73-74 date that you mention is absolutely spot on, and in fact the first fruits as it were of Clockwork Orange were in January of 74. Do you recall when you first heard the title Clockwork Orange?

LENG: To tell you the honest truth it doesn't ring an awful lot of bells in my mind, I have to say that now after 17 years.

PENROSE: No, sure.

LENG: I think it would ring more in Frank Kings ears.

PENROSE: Yes. I mean, so you, it is correct in saying that it would be you and Frank King or Frank King and you rather, that would authorise...

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LENG: If it was something on policy Frank King would authorise it. I mean all I actually, if must be quite honest, all I really recall is all to do with the young offenders' home and what went on there.

PENROSE: Yes. The Kincora...

LENG: That is what I was brought into - not necessarily the homosexuality, but the fact that the boys were escaping all the time.

PENROSE: Yes, I remember your saying.

LENG: That was my main involvement with that side.

PENROSE: And recommending the police be brought...

LENG: The rest hardly rings a bell in my mind at all.

PENROSE: No, except that you were saying intelligence gathering takes a long time and in fact it went on for about a year, and you said it could be six months to a year.

LENG: Yes, however long it takes - but intelligence takes a hell of a long time to get, as I discovered.

PENROSE: Yes. I mean the thing, the reason why Clockwork Orange - So you authorised Clockwork Orange as a policy so that...

LENG: I didn't authorise Clockwork Orange as a policy. If it were authorised, it would have been authorised by the Northern Ireland Office and being that sensitive it would go to Frank King or the Intelligence office and not to me.

PENROSE: Although in this case you were saying that you did know about it because of course you had to authorise Peter Gough's, and the others to hand sensitive information about terrorists to the...

LENG: That was the normal practice, that goes on today.

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PENROSE: Yes

LENG: I mean that was part of the routine of our life.

PENROSE: Yes I understand..

LENG: ... intelligence about terrorists.

PENROSE: Yes, indeed. But Clockwork Orange was going to be an operation that was new in the sense of obviously focussing on certain things about the paramilitary - I mean the terrorists.

LENG: Well yes, but if I may say so, that goes on all the time. Collecting information about both sides of the divide.

PENROSE: Yes. So what was it about Clockwork Orange that was different, it anything at all?

LENG: I can hardly remember it to tell you the honest truth.

PENROSE: Yes.

LENG: I'm not much help there.

PENROSE: No, no, I understand. But you knew it simply as being information about terrorists.

LENG: That's right. Absolutely.

PENROSE: So when as you said, and others have said the same thing about you and indeed about Frank King, that you said you know straight wicket here, this has got to be kept clean, and so on. Now the other side of the coin, and for this you have obviously, and I understand this and I ... you know, this is important, that you had no knowledge about the fact that others were devilling. I mean there seems to be little doubt because in

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fact there have emerged in fact while you have been away, and I have also been told by people involved, that what they were doing was often marrying information for example, about terrorists with information that came from Dennis Paine's organisation, MI5, which was - about politicians. Let me give you if I may just a quick illustration of that, that has been described to me, and that was this. For example, in Clockwork Orange there was one little operation that was tried on the Daily Telegraph - in actual fact it was aborted by the people doing it because it would have become public of how they were trying to do it. This is what they did. They got in touch with, by forging a letter, apparently from an IRA man to the Telegraph, and they said look, the letter said something like, I am an IRA man, I am disenchanted, I am quite senior in the movement, I want to sell my story and tell you all about how I am disenchanted. So the letter arrived, and it said in the letter, if you are interested, put a personal ad in the Telegraph and that is how we'll communicate. Well the Telegraph did that and a man called Bartlett, the reporter who got the letter, was coming across to Northern Ireland to meet the disenchanted terrorist. In the letter it also said that - there was quite a bit about Harold Wilson saying what a good trip it had been for Wilson because Wilson had apparantly said how good the IRA was - it was knitted well together, the security was good and so on. Now this was obviously complete nonsense because, a) it had nothing to do with Wilson and it was quite simply.....Peter Broderick took a call from the Telegraph man who said - marvellous story, I'm coming over because of this disenchanted IRA man and I am going to interview him if its all correct. And Broderick then turned to the information policy unit and said - look this chap from the Telegraph has rung, do we know anything at all about it? And they said - Good Heavens above, why has he called you - this is one of our operations that he doesn't know about and they immediately wrote to the Telegraph with another forged letter to say sorry, can't deal with you. You are obviously not trustworthy because you have been in touch with the security forces. Now the whole thing disappeared, it was aborted. So there was an example where people not in - I mean where there was a tug of war so to speak, between your clean policy and the policy of MI5 or some of them there, who wanted to, you can see the point, use it for dirty tricks.

(ENG: Who started that one up?

PEHROSE: Well it seems very clear that these were either middle grade MI5 officers.

I cannot believe that Sir Michael Hanley for example would authorise that.

(ENG: I'm sure not.

PEHROSE: I mean it doesn't make any sense.
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LENG: Yes.

PENROSE: It would have all blown up in his face. *It seems to be the kind of slightly right of Genghis Khan figures like Peter Wright and so on.

LENG: Yes.

PENROSE: You know - so that is apparently what happened, and also there are so many examples that were in the Clockwork Orange file, which of course you did not see, where this is what appears to have happened and that's where it got out of control.

LENG: Yes - um - I think that's right, but it certainly didn't come high up and I don't know where that would emanate from frankly, because certainly - I mean I can't see any of us being clever enough to do that.

PENROSE: No, no, quite. No, no, absolutely. I mean...

LENG: Indecipherable few words

PENROSE: But the point is, you see, you can see how, this is quite clearly what happened. I mean for example I have seen one particular document that was in Clockwork Orange, it was 134 pages, absolutely full of very right wing stuff about Labour, Liberal and also about Ted Heath and other people, obviously with the idea of sorting that in with material about paramilitaries, and that seems to be what was happening over there.

LENG: That I can assure you, I mean there was absolutely nothing that I ever recall that tried to denigrate politicians.

PENROSE: No.

LENG: I mean it wouldn't, it's not what we are there for. The army supports whatever government is in power whether we like them or not, but we certainly wouldn't go into what I call black propaganda like that, that would be dreadful. And indeed, all our life was directed into trying to deal with the IRA and UDF terrorists and politicians wouldn't come into it. No way would it benefit the land army to run politicians down in any way at all. It would do us a lot of harm.

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PENROSE: A lot of harm in fact - because - I mean - there would have been Parliamentary enquiry - I mean there would have been a royal commission and so on. So infact, I mean, so that although when Dennis Paine sends over, well not sends over but discusses' would you be in on that discussion?

LENG: No not necessarily, intelligence to intelligence was always kept absolutely at that one line.

PENROSE: So that's five to army intelligence

LENG: That's right.

TO HER

PENROSE: And it only, as it were, comes on your desk, because you have to presumably initial something to say OK for Peter Goss and others to hand....

LENG: Its all verbally and minutes would be kept of that and then destroyed after a certain time.

PENROSE: Indeed. So you did that and said "that's fine, you can..."

LENG: I hardly ever saw a minute I must admit, from intelligence or from any other people because we discussed it across the table and then said we'll do this and do that. That's the way we operate.

PENROSE: And in 74 of course it would have been ... GOC was Frank King then, so he would have had to have nodded it, and you down the line.

LENG: Absolutely.

PENROSE: Yes, that's how it worked. I mean it is pretty incredible now that this is emerging as the pattern of people who clearly were out of control and also could have brought the army into disrepute if this had emerged then. I mean it will emerge of course there is a parliamentary enquiry. But it is an extraordinary story, I mean it...

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LENG: I tend to read the book of that because in a curious way, as a Major General, one is fairly naive about things and one just gets on with the operation.

PENROSE: Yes.

LENG: And I sort of travelled every afternoon going to units, discussed early in the morning what had happened the night before and how you were to handle the tactical situation, and that frankly seemed to be a fairly straightforward ... I would't say normal, but kind of normal job and I was very ... I mean I didn't get myself involved in intelligence work. I mean, you know, occasionally someone would come up with a strange idea and then one would knock it on the head.

PENROSE: Yes. You mention, I mean, about the diary, something of that kind you just knocked it on the head....

LENG: Indeed. I think I seem to remember someone said - we haven't enough evidence to prosecute terrorists, why don't we stick a poster up on a wall saying they are IRA terrorists and leave it to the protestants. Well these are the sort of wild ideas that came up and you can imagine the answer.

PENROSE: Frank King gave a marvellous example where he said that your chaps got hold of an IRA poster and superimposed on it the The Ballot or the Bullet, or something like that. Eventually the IRA thought they were marvellous so they put these up as well. He gave one example like that.

LENG: But I think that was very rare ...

PENROSE: Yes.

PENROSE: Because they are not very good at it.

PENROSE: No, no sure. But I mean clearly the other people, I mean at five and the policy unit people who were working with them ... because you'll see in fact in Foot's book, it's not as detailed as it might be in some places but what Wallace and others found was that their loyalties were being tugged from both sides. Here for example, he was meeting Dennis Paine and somebody else whose name I forget from five, who hands in all these files, saying "Now sort these things into reports to the press

(MORE)

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that you are supposed to be giving to the Press from time to time.

LENG: Yes.

PENROSE: ... and on the other side of course, he dare not mention that to Peter Broderick because Broderick would go mad. So that's why it led up to of course the bang that led to his being you know forced to resign and the rest obviously you know. Well, anyway, that should arrive in the morning, that book. And um...

LENG: Very kind, thank you.

PENROSE: Not at all. Goodbye.

LENG: Goodbye.
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UNIDENTIFIED INTERVIEWEE to 352

UNIDENTIFIED INTERVIEWEE ''Hartlebury'' TO 709

Continuation of above (probably).
(END)

Contents

Chapter 29:

Module 15 – Kincora Boys' Home (Part 2)

Summary of Conclusions

1 In the preceding chapters we examined in detail:

- the experiences of the residents in Kincora;
- the way in which the Belfast Welfare Authority and the Eastern Health and Social Services Board responded to complaints and concerns made known to them about the actions of Mains and McGrath in Kincora;
- the way in which the RUC responded to the complaints and concerns relating to Mains and McGrath made known to it;
- what the intelligence agencies knew of abuse of residents in Kincora during the 1970s; and
- the response of the Government in later years to those allegations.

2 In this chapter we draw together in summary form our conclusions on the various matters relating to Kincora that we examined in the preceding chapters. These conclusions are intended to be read in conjunction with our detailed examination of the evidence, and subject to the fuller reasons for our conclusions that we expressed in those chapters.

3 Despite the convictions of Mains, Semple and McGrath in 1981 allegations have persisted that state agencies were either complicit in, or turned a blind eye to, the sexual abuse of residents in Kincora. As we have explained, during the 1980s there were four major RUC investigations into various allegations about Kincora. The first of these investigations (Caskey Phase One) resulted in the convictions of Mains, Semple and McGrath. Because the three defendants pleaded guilty this meant that only a relatively brief explanation of the facts relating to their offences was outlined in court.

4 Because the Caskey Phase Two, Three and Four investigations did not result in prosecutions, the details of those extremely comprehensive investigations have not been publicly disclosed until this Inquiry. Although Sir George Terry, D/Supt Harrison and D/Supt Flenley from the Sussex Constabulary reviewed the way in which the Caskey Phase One investigation had been carried out, and oversaw the Caskey Phase

Two and Phase Three investigations, the detailed work done by D/ Supts Harrison and Flenley has never been publicly examined until now because Sir George Terry only published his conclusions.

5 In 1984 and 1985 the Hughes Inquiry thoroughly examined some of the allegations relating to Kincora as part of its wider examination of the sexual abuse of children in a number of local authority homes and hostels. However, its restricted Terms of Reference confined its examination to the actions of Social Services. The actions of the RUC were only touched upon in that Inquiry in the context of what the EHSSB officials were told in 1976 in connection with the Cullen/Meharg investigation. The Hughes Report was published in 1985, but copies are scarce and it is not readily available. In addition, the transcripts of the evidence given largely in public in over 60 days of hearings, much of which related to Kincora, were not publicly available.

6 A great deal of relevant information about Kincora has therefore never been disclosed before, nor has it been examined, over the 36 years since the sexual abuse of residents in Kincora came to public attention. During those 36 years many allegations have been made by journalists, writers, public representatives and others about what they say did happen, or believe may have happened, in relation to the involvement in, or knowledge of, sexual abuse of residents at Kincora by people other than Mains, Semple and McGrath.

7 As a result the subject of Kincora, and what did or did not happen to the residents there, and what was or was not known about that abuse before it was exposed in 1980, came to resemble a deserted building so completely overgrown that it was extremely difficult to identify any parts of the original building apart from the outline of the structure and some of its principal features. This Inquiry carried out the first public examination of a mass of evidence that has hitherto not been publicly revealed, some of which came from sources which have not hitherto been examined by any person outside government and the intelligence agencies.

8 As a result of our examination of all of this material we believe that we have stripped away the overgrowth of decades of ill-informed comment, half truths and deliberate misrepresentations which have all too often masqueraded as established facts because they have been constantly repeated without critical analysis by, or real knowledge on the part of,

those who have offered public comments about the nature and extent of the sexual abuse of residents in Kincora, and what state agencies did or did not know about that abuse during the 1970s. We have established that the sources of many of the allegations were untruthful, inaccurate or mistaken in what they said had happened.

9 Kincora was established as a working boys' hostel in 1958. Although the concept of a working boys' hostel was an excellent one, and there were positive aspects to the way it operated, such as the efforts made by Mains to find employment for the boys, there were several systemic failings in the way it operated. It was never adequately staffed, and this meant that for significant periods only one member of the care staff was on duty in the building. Although some residents were under school leaving age, most had left school and so were usually in work. If a boy was unemployed, or absent from work due to illness or for some other reason, this often meant that he would be on his own in the hostel during the day.

10 Because most of the residents were boys of working age they were able to come and go with much greater freedom than would have been the case if they were younger residents in a children's home. Many residents went out socially at night or weekends, whether to go to pubs or to go home to their families in some cases. For all of these reasons it was not uncommon for a resident to be on his own in the house at some point during the day or at night before everyone retired to bed.

11 Kincora was a hostel for boys who had reached school leaving age, but too many children were admitted to Kincora when they were under school leaving age. These children were too young to be placed in such an environment, and too many of them spent too long in that environment when they were admitted. In addition, there were insufficient staff with appropriate training or experience to deal with such young children.

12 Understaffing also meant that staff had to work very long hours, particularly in the case of Mains during the early years, when he was the only member of the care staff for a very long period of time. This meant that he was effectively expected to be on duty all the time. This was very poor practice, and the long hours and low pay put significant pressure on staff, and meant that recruitment of suitable staff was very difficult. This was demonstrated when Semple resigned in 1966 and the Belfast Welfare Authority were unable to find a long-term permanent

replacement for him. This meant that when Semple applied for the vacancy created by his own resignation he was reappointed because a suitable person could not be found, despite Mains's knowledge of Semple's sexual abuse of residents. The insufficient levels of staff provided Mains, Semple and McGrath with opportunities which they exploited to target their victims when no one else was about to see what was happening, or to suspect what was happening.

13 Whilst Mains and Semple knew each other before Semple was appointed as deputy warden, and Mains definitely knew of Semple's sexual abuse of residents before Semple was reappointed, there is no evidence either knew McGrath before he was appointed.

14 The evidence suggests that by the time McGrath was appointed Mains had stopped sexually abusing residents, and was engaged in a long-term homosexual relationship with an ex-resident. Semple did not engage in sexual abuse of residents after he was reappointed, and found outlets for his sexual urges elsewhere. This meant that McGrath was the only member of staff who abused residents between his appointment in the summer of 1971 until the home was closed in 1980.

15 The way the adolescent boys in Kincora were looked after meant that far too much was done for them by the domestic staff. We consider this created an attitude of dependence by the boys on the staff, and this dependency was exacerbated by inadequate preparation of the residents for independent living when they left Kincora.

16 The Ministry of Home Affairs, and then the DHSS, failed to maintain an adequate inspection regime of the hostel.

17 Kincora opened in 1958 and closed in 1980. During that time 309 boys resided in the hostel. In their investigation in 1980 the RUC took 1963 as the starting point for their investigation. Of the 245 boys who resided in Kincora between 1963 and 1980, 104, (42% of the total), were traced and interviewed by the police. We now know that 38 boys were abused at some point during Kincora's existence. Although not all the surviving former residents could be traced, or have since come forward, it can be seen from these figures that the great majority of those who were traced were not sexually abused during their time in Kincora.

18 Indeed the great majority of residents of Kincora who were interviewed by the police were unaware at the time of what was happening in the hostel, and were very surprised to learn of the allegations that emerged afterwards. For example, of 92 former residents of Kincora between 1966 and 1980, 76 (that is 88.33%) told the police they were surprised by the allegations of the extent of sexual abuse that took place during their time in Kincora, even though some of them described how they themselves were abused, or had engaged in homosexual activity with others, whether with McGrath or other residents.

19 It may seem strange that so many of those who were in and out of Kincora in various capacities, not just the residents but the domestic staff and visitors, were unaware of what was happening, but there was a consistent pattern of concealment of their behaviour by Mains, Semple and McGrath.

20 They approached boys who were vulnerable, or who they thought might be easily intimidated. If their initial approaches were firmly rebuffed they generally did not approach that person again. If they did, they went to considerable lengths to approach the boy when others were not around.

21 During McGrath's time at Kincora he appears to have often worked in the evenings and in the mornings, when Mains or Semple was not about, because the duties involving the supervision of the residents were distributed between all three. Mains had other administrative duties as well, and our impression was that more of the direct supervision of the residents in the 1970s was carried out by Semple or McGrath, and because of the way their duties were arranged McGrath was often on duty on his own.

22 When complaints were made by residents, first of all to the Belfast Welfare Authority, and later to the EHSSB, these were not properly dealt with. In 1967, when the first complaints were received, Mr Mason decided that Mains's conduct did not amount to a prima facie indication of wrongdoing. We consider that he was wrong to do so. The Town Clerk's Department was wrong not to implement Mr Mason's recommendations that clear procedures be put in place to ensure that any further complaints about Kincora were properly reported to the City Welfare Officer. Written and clear instructions should have been given to relevant managers for the closer supervision of Kincora in the future.

23 Again in 1971 the Town Clerk and Town Solicitor did not report the allegations to the police as they should have done. Following the decision not to report the allegations to the police the following steps ought to have been taken.

1 It should have been re-emphasised to Mains that he should avoid doing anything that could lead to allegations of impropriety.

2 Instructions should have been given that a very close eye was to be kept on both Mains and Kincora.

3 Procedures should have been put in place to ensure further allegations about Kincora were properly collated and then referred to the City Welfare Officer, or to his deputy, for immediate attention.

24 After 1971 and throughout the remainder of the 1970s, anonymous phone calls and rumours that appear to have circulated about Kincora amongst staff and other social workers were not made known to senior staff in the EHSSB as they ought to have been.

25 When the RUC told the EHSSB in 1976 of the allegations against McGrath, the EHSSB did not give clear written instructions to ensure that there would be increased supervision of Kincora, of Mains and of McGrath, and staff did not pass to the EHSSB management important information about allegations against McGrath. EHSSB management did not take sufficient steps to press the RUC to find out what was happening with the RUC investigation.

26 In 1974 when the RUC became aware of the allegations made by Roy Garland against McGrath, about which he reminded them in 1976, the Cullen/Meharg investigation was inept, inadequate and far from thorough. The response in 1974 by D/Supt Graham to what he was told by Valerie Shaw about McGrath was wholly inadequate.

27 It was not simply the case that over these years there were a small number of missed opportunities by the Belfast Welfare Authority, by the EHSSB and by the RUC. There were so many failings by all of these agencies that they amount to a catalogue of failures by each. Had the 1971 allegations been reported to the RUC, as they should have been, or if an effective investigation had been carried out by the RUC in later years, it is reasonable to infer that a thorough and competent investigation by trained detectives may have been successful in exposing the abuse in 1976, and possibly even in 1974. This would have meant

that those who were sexually abused after 1976, and possibly after 1974, would have been spared their experiences.

28 Over the years, much attention has been devoted to what the RUC, MI5, the Secret Intelligence Service and Army Intelligence knew about the sexual abuse in Kincora, when they knew and what they did with that knowledge. We are satisfied that the interest of the RUC Special Branch, of MI5, of SIS and of Army Intelligence in William McGrath was solely because he was the commanding officer of Tara. Their interest in Tara came about because there were indications that this clandestine organisation, although it claimed to be a peaceful organisation designed to function only if there was a complete breakdown of law and order, might turn into another armed Loyalist terrorist organisation. There were reports that members of Tara were trying to obtain, or had obtained, quantities of arms, and that many of its members were members of the Ulster Volunteer Force, a Loyalist terrorist organisation.

29 We are satisfied that the RUC Special Branch first learned of William McGrath in July 1966 when he was reported as present as one of the platform party at a rally led by the Reverend Ian Paisley in the Ulster Hall in Belfast. McGrath was otherwise an unknown figure. In 1971 MI5 learned that a man named McGrath was reported to be the OC of Tara. However, despite efforts to establish who this person was, and gathering much information about him that was inaccurate, it was not until April 1973, 20 months later, that RUC Special Branch identified the Commanding Officer of Tara as the William McGrath seen on the platform in 1966. It seems that it was not until November 1973 that MI5 learned that the OC of Tara and McGrath were one and the same person, probably as the result of a letter sent to MI5 in November 1973 by RUC Special Branch.

30 The intelligence agencies soon concluded that Tara was not a significant force, and they only paid intermittent attention to it and to McGrath in succeeding years.

31 By May 1973 both RUC Special Branch and other RUC officers knew that McGrath was reputed to be homosexual, but they had no proof of this. It was not until Roy Garland spoke to Detective Constable Cullen on 1 March 1974 that the RUC received an allegation that McGrath had engaged in homosexual conduct of a grooming nature in the past with Roy Garland when Roy Garland was a teenager. For understandable

reasons Roy Garland was not prepared to come forward to give evidence at that time, and the result was that the RUC had a witness who would not appear in court and who was describing events involving homosexual acts that had occurred a considerable number of years before.

32 Although in 1973 the RUC Special Branch were aware of the allegation that McGrath was homosexual from another source they did not pass the information relating to the other source to their RUC colleagues as they should have done. Had Special Branch passed on that information then their RUC colleagues, whether in CID or in uniform departments, could have added it to the information that they had already received from the anonymous Robophone message.

33 Despite Roy Garland's commendable efforts to alert Social Services and the RUC to the risk he accurately identified that McGrath might be taking advantage of his position in Kincora to sexually assault residents there, just as he had sexually assaulted Roy Garland when a teenager, Roy Garland's efforts to do so were unsuccessful through no fault of his own.

34 Although the RUC (SB), MI5, SIS and Army Intelligence were all aware of allegations that McGrath was homosexual, such allegations were common at the time against various political and other figures. In the absence of positive evidence of homosexual acts there was little that could be done by these agencies.

35 We are satisfied that it was not until 1980 that the RUC Special Branch, MI5, the SIS and Army Intelligence became aware that McGrath had been sexually abusing residents at Kincora, and they learnt of that when it became the subject of public allegations and a police investigation was launched. All four agencies, whilst aware that McGrath was alleged to be homosexual, had no proof of that. They were aware that he worked in a boys' hostel where he was in a position of authority.

36 However, by November 1973, MI5, unlike the other three agencies, were also aware that the person who had by then been identified as William McGrath had been accused of "assaulting small boys" in April 1972. By virtue of Section 5 (1) of the Criminal Law Act (Northern Ireland) 1967 MI5 officers were subject to the same legal obligation as everyone else in Northern Ireland to report the commission of an "arrestable offence" (that is an offence punishable by five years imprisonment) to the police where they knew or believed that such an offence, or some

other arrestable offence, had been committed. An alleged assault on small boys could, depending on the nature of the alleged assault, have been an arrestable offence which ought to have been reported to the police.

37 With the benefit of hindsight, and in the light of what is now known about McGrath's abuse of residents in Kincora, it might be argued it was the duty of MI5 to bring to the attention of RUC Special Branch that MI5 had received a report that McGrath had been accused of assaulting small boys, and that by not doing so the MI5 officers who had this information were in breach of that duty. However, we consider that to take that view would be unjustified for several reasons. First of all, although the information was known to MI5 because it had been received eighteen months before, eighteen months separated the receipt of that information and the information confirming the identity of William McGrath as the leader of TARA. Secondly, the information came to MI5 in a letter from James Miller who was simply reporting what an unidentified source said at a time when unsubstantiated allegations of discreditable behaviour by TARA members about each other were commonplace, and the report was therefore assessed as being of dubious reliability. Thirdly, the MI5 officers were concentrating on establishing what sort of organisation TARA was, and whether it could be a possible Loyalist terrorist group in the context of the extremely volatile political and security circumstances of that time. In all of those circumstances we do not criticise them for failing to appreciate the significance of this information.

38 We consider that had this information been passed to the RUC Special Branch, and by it to their CID and uniformed colleagues, that information may still not have made a significant difference to the approach of the RUC. The RUC had received, and was to receive, much more detailed allegations from the Robophone message, from Valerie Shaw's conversation with D/Supt Graham, and from Roy Garland's conversation with DC Cullen that brought about the Cullen/Meharg investigation. An anonymous allegation of assault on small boys in an unspecified context and at an unknown point in time that had been passed by MI5 might not have added much, if anything, to that information. On the other hand, we consider that if it came from MI5 it might have prompted the RUC to look at the existing information it held about McGrath and to investigate it more robustly.

39 Based on our extensive examination of a very large number of files held by RUC Special Branch, by MI5, by SIS and by the Ministry of Defence, we are satisfied that McGrath was never an agent of the State, although he may have enjoyed creating an air of mystery about his activities, part of which may well have involved him hinting at, or implying in an oblique fashion, that he was an agent of the State.

40 Not only have we found no evidence to indicate that McGrath was an agent of any of the four agencies, we have found many documents and references which very strongly indicate that he was not an agent. For example, the discussion in early 1977 between MI5 and the SIS that it might be worthwhile penetrating Tara. Why would this be necessary if the Commanding Officer of Tara was already an agent? Another indication that McGrath was not an agent was the way he was named in a number of Daily Intelligence Summaries, some of which at least were intended to be read by a large number of individuals. To broadcast an agent's name in that way would be contrary to all intelligence practice, and that McGrath's name was circulated in this fashion strongly suggests he was not an agent or even a source.

41 No doubt there will be some who argue that such considerations can be explained away as Machiavellian cunning to conceal his status as an agent by placing him in full sight. However, the reality was that William McGrath was a sexual pervert who had political and religious views of an extreme and bizarre type who managed to trick gullible young men who were interested in political matters into regarding him as an important political figure. In reality we consider that William McGrath was never more than a minor player on the wider political stage who managed to create a spurious air of self-importance through Tara at a time of great political instability, communal violence and terrorist activity. Tara was never more than an organisation of occasional interest to the intelligence agencies.

42 There have been frequent allegations that various individuals, including Sir Maurice Oldfield, a former head of the Secret Intelligence Service who was later the Security Coordinator in Northern Ireland, and a number of named and unnamed Northern Ireland Office Civil Servants, and unnamed business men and other prominent figures, resorted to Kincora for sexual purposes. We are satisfied there is no credible evidence to support any of these allegations. Kincora was a small hostel and for most of its existence had only nine or fewer residents

at any one time. As we have already pointed out, the great majority of all of those residents who were interviewed by the Sussex Police were very surprised at such allegations and did not believe them to be of any substance.

43 There were a small number of former residents of Kincora who returned to Kincora as visitors and who engaged in consensual homosexual activity with Mains, or on a small number of occasions, with some of the residents. A number of residents engaged in consensual homosexual activity with each other, or did so with others away from Kincora in circumstances which were completely unconnected with Kincora. We are satisfied that Kincora was not a homosexual brothel, nor used by any of the intelligence agencies as a "honey pot" to entrap, blackmail or otherwise exploit homosexuals.

44 Both the Belfast Town Clerk and the Town Solicitor died before the Hughes Inquiry investigated the sexual abuse at Kincora. The reasons why the Town Clerk and the Town Solicitor decided not to accept the recommendation made by Mr Mason in 1971 that the complaints against Mains should be reported to the RUC were never recorded. There are a number of possible reasons why they took this step. One was that they did not agree that the information contained in Mr Mason's report was sufficient to justify the matter being reported to the police. If that was their reason then that was a wrong decision. Another reason may have been to protect the Belfast Welfare Authority from the embarrassment that would flow from a police investigation into a boys' hostel under its control. Another explanation may have been that either or both were determined to protect Mains from exposure as a homosexual. That would only be a possible consideration were there evidence to show that either the Town Clerk or the Town Solicitor knew that Mains was a practising homosexual. In the absence of any evidence, each of these possible reasons is no more than speculation.

45 Apart from that unexplained decision, we are satisfied that there were no attempts by the Belfast Welfare Authority or the EHSSB to engage in a "cover-up", that is concealing from relevant individuals or authorities their knowledge of, or information about, wrongdoing by Mains, Semple or McGrath.

46 We are satisfied that Mr Wallace was moved from his post in the Army Information Service at HQNI, and subsequently dismissed, solely

because there was very strong circumstantial evidence that he had been engaged in, and was still engaged in, the unauthorised disclosure of classified documents and information to journalists. We are satisfied that whatever he claims to have known about Kincora had nothing whatever to do with his posting to Preston or his subsequent dismissal.

47 We are satisfied that Mr Wallace was treated unjustly in two respects connected with the subsequent appeal he brought against his dismissal to the Civil Service Appeal Board. First of all the MoD did not reveal to the CSAB the full job description which had been prepared showing the true nature of his work. Secondly, the MoD briefed the Chairman, and then the Deputy Chairman, of the CSAB with information that was not made known to Mr Wallace, to his representative, or to the other members of the Board who sat on his appeal. That they did so, and that the gentleman concerned received the information, was thoroughly reprehensible and should never have happened.

48 These injustices were accepted by David Calcutt QC in his report to the MoD in which he recommended that Mr Wallace be paid £30,000 compensation. We understand that Mr Wallace eventually accepted this amount.

49 For the reasons we have given in the previous chapter we do not regard Mr Wallace as truthful in his accounts of what he knew about sexual abuse in Kincora, or of what he did with that knowledge, between 1972 and 1974. In particular, for the reasons we have given, we do not accept that the critical document of 8 November, 1974 was authored at that time.

50 During the Caskey Phase Three investigations MI5 consistently obstructed a proper line of enquiry by their refusal to allow the RUC to interview a retired MI5 officer, and by their refusal to authorise that retired officer to provide a written statement to the RUC answering 30 questions the RUC wished to ask him. We consider these questions were proper and relevant questions to the enquiry being conducted by D/Supt Caskey at that time.

51 While the Sussex Police carried out a thorough re-examination of the way the RUC carried out the initial Caskey Phase One investigation into the offences committed by Mains, Semple and McGrath, Sir George Terry was not justified in stating that military sources had been "very frank with me and perfectly open".

52 The reliance by the NIO on the decision by the DPP that there should be no prosecution, and on Sir George Terry's Report, as adequate reasons for not setting up an Inquiry with Terms of Reference that would have enabled an investigation of the issues relating to the security agencies was not justified at the time. The decision failed to properly take account of the public disquiet at the time about issues which were deliberately excluded from the Terms of Reference of the Hughes Inquiry. This disquiet has persisted in certain quarters, but this Inquiry has now been able to investigate these matters.

53 The realisation by the MoD in 1989 that incorrect answers may have been given by Ministers to the House of Commons and to others led the MoD to carry out a wide ranging and detailed investigation to establish the correct position. When the correct position was known, the Ministry took the necessary action to place the correct facts before the House of Commons and to correct the errors that had occurred in the past. It appointed Mr Calcutt QC to consider the injustices suffered by Mr Wallace to which we have already referred. We are satisfied that once the MoD appreciated that incorrect information had been given, and that Mr Wallace had not been treated properly before the CSAB, it acted promptly and properly to establish the correct position, and to ensure that the injustices Mr Wallace suffered in the appeal process where remedied. The injustices were remedied by the payment of £30,000 to him as compensation.

54 Those residents of Kincora who were sexually abused by Mains, Semple and McGrath were let down by those three individuals who abused their positions of authority and committed numerous acts of sexual abuse of the gravest kind against teenage children in their care while they were living in this hostel. When their conduct was exposed, they were prosecuted, convicted and sentenced to appropriate periods of imprisonment.

55 In our investigations this Inquiry has examined hundreds of files held by Government and by the Police, MI5, the Secret Intelligence Service, the Ministry of Defence and other departments and agencies. We have also examined the police files relating to the earlier investigations that were carried out by the RUC and then by the Sussex Constabulary into what did or did not happen at Kincora. As we explained, those investigations by the RUC and the Sussex Police were extremely thorough and comprehensive. D/Supt Caskey and his officers went to great lengths

to identify every possible person who may have been in possession of information that could lead to the identification and possible prosecution of anyone else who had committed a criminal offence of whatever kind relating to Kincora, whether that was sexual abuse or the suppression of evidence.

56 Those investigations did not find, and our Inquiry has not found, any credible evidence to show that there is any basis for the allegations that have been made over the years about the involvement of others in sexual abuse of residents in Kincora, or anything to show that the security agencies were complicit in any form of exploitation of sexual abuse in Kincora for any purpose.

57 The reality of the situation was that it was because of the multitude of failings by officials of the Belfast Welfare Authority, of the Eastern Health and Social Services Board, and by the RUC, that the sexual abuse of residents at Kincora was not stopped earlier, and that those responsible for perpetrating these grave crimes were not brought to justice sooner.

HIA Historical Institutional Abuse Inquiry

HIA Inquiry, PO Box 2080, Belfast, BT1 9QA, Northern Ireland.
T: 028 9072 0600 E: general@hiainquiry.org W: www.hiainquiry.org

31st March 2015

This is the report of the Acknowledgement Forum. The content is agreed by the four members of the Forum, Beverley Clarke, Norah Gibbons, Dave Marshall, and Tom Shaw.

Beverley Clarke

Norah Gibbons

Dave Marshall

Tom Shaw

Contents

Chapter 1:

Chapter 1: The Acknowledgement Forum

Introduction

1 The appointment of the Chairman of the Historical Institutional Abuse Inquiry (hereafter the Inquiry) and the four members of the Acknowledgement Forum (hereafter the Forum) was announced by the First Minister and deputy First Minister on 31 May 2012.

The Purpose of the Forum

2 The principal purpose of the Forum was to allow applicants to talk informally and in whatever detail they chose about their experiences when placed in designated residential childcare establishments in Northern Ireland and, in doing so, to feel confident that what they experienced was being acknowledged and listened to in good faith. The process did not involve investigative questioning but the Forum offered to assist applicants in describing their experiences by putting some questions to them. The Forum meeting provided applicants with the time and the opportunity to be heard without challenge or disbelief – an element of their experience as children in designated establishments that may have been denied to them.

Arrangements for Applicants Meeting with the Forum

3 To ensure everyone had an appropriate context in which to recount their personal experiences in what, for many, could be a difficult and painful process, a number of carefully considered steps and arrangements were put in place.

- Following receipt of the applications by the Inquiry, each person was contacted by one of the Inquiry's Witness Support Officers (WSOs) who arranged an appointment in a way that was suitable for that person. The WSOs ensured that practical arrangements regarding travel to the Inquiry's premises – and overnight accommodation where required – were in place prior to the meeting with the Forum. The WSOs were also able to answer any queries an applicant may have had about the Inquiry, including the Forum process.
- A letter was sent to each applicant setting out clearly the exact arrangements for the meeting with the Forum. The applicants were told that they could bring with them any papers, correspondence or

photographs relating to their placement(s) in designated establishments in Northern Ireland and all such documents, if they agreed, would be scanned into the Inquiry's records.

- Each applicant who wished to do so could bring a companion with him or her. The companion could be present for the meeting with the Forum or could stay in an adjacent waiting room. Some of those who accompanied applicants chose to leave the premises and come back when contacted by the WSOs or the applicant when the meeting with the Forum had concluded. The choice was in the hands of the applicant. The role of the companion was intended to be a supportive one. By the end of the Forum's work, 86 of the 261 male applicants and 58 of the 166 female applicants had chosen to have a companion present but many attended for their meeting alone. In the event that the companion was also an applicant to the Forum or to the Statutory Inquiry, that person was not allowed to accompany the applicant during the meeting.

The table that follows contains a summary of this information

	Male	Female
Accompanied but not during the meeting	38	42
Accompanied during the meeting	86	58
Unaccompanied	137*	66
Total	**261**	**166**

*One applicant's account of his experiences was presented in written form. He is not included in this total.

4 Applicants' companions consisted of partners, family members, friends, people giving them specialist support and solicitors.

Accompanied but not during the meeting with the Forum

Accompanied but not during the meeting	Male	Female
Partners	10	9
Family members	16	15
Friends	11	17
Support personnel	-	1
Solicitors	1	-
Total	**38**	**42**

Accompanied during the meeting with the Forum

Accompanied during the meeting	Male	Female
Partners	36	16
Family members	13	19
Friends	8	11
Support personnel	22	10
Solicitors	3	2
Interpreters only	4	-
Total	**86**	**58**

Reception of Applicants for Meetings with the Forum

5 The WSOs met the applicants – and any companions – when they arrived for their appointment. They were offered a quiet room to relax in and a welcoming cup of tea or coffee. They were told the names of the Forum members who would meet them. The WSOs made every effort to assist the applicants in settling themselves for the meeting with the Forum members.

The Arrangements for Forum Meetings

6 When ready, the applicant was shown into the room where he or she would meet the panel members who would listen to the account of his or her experiences. Generally panel members worked in pairs – a male and a female. In a small number of cases, applicants requested a meeting with one Forum member or with two female or two male panel members; those requests were agreed.

7 Meetings with the Forum did not follow a strict format. As already explained, each meeting was designed to allow the participants to describe their experiences in the way that they chose. At the beginning of each meeting, Forum members welcomed the applicant, outlined the purpose of the meeting, and asked permission to take notes and make a recording of the meeting. Each applicant was assured that he or she could take a break at any time, and was given the opportunity to ask questions of the Forum members. Each participant was also informed of the legal requirement on all citizens in Northern Ireland to report a crime of which they become aware to the Police Service of Northern Ireland (PSNI). All applicants accepted this and some welcomed the information as reassuring.

Recording Forum Meetings

8 In accordance with the Inquiry's Terms of Reference and the assurance given to applicants at the beginning of their meetings with the Forum, all notes taken during the meetings were destroyed once the details were recorded in the Forum's secure database. It was explained to applicants that the information recorded by the Forum members in its database would be used solely for the purpose of informing the report that the Forum would be required to prepare when the meetings with applicants had concluded. They were also told that the information in the database would be deleted once the Forum's work was complete.

9 The design of the database was informed by the model developed by the Ryan Commission for its Confidential Committee. The Forum acknowledges with gratitude the benefits of having access to the expertise and experience of the Confidential Committee.

10 Some applicants brought personal papers, files and photographs to support them in their accounts and provide an assurance of the veracity of what they intended to tell the Forum. The originals of those papers and photographs were returned to the applicants either at the end of the meeting or were posted to them afterwards. For those intending to proceed to the Statutory Inquiry the papers and photographs were scanned into a secure database before being returned to applicants.

11 Following this, and when the applicants felt ready to proceed, they were invited to talk about their own experiences. In some instances it proved necessary for one of the Forum members to leave the meeting for a time at the applicant's request, for example when the applicant wanted to recount events that caused deep embarrassment or difficulty in the presence of, in some cases, a female and, in others, a male.

The Duration of Forum Meetings

12 All applicants were free to decide how they would proceed with recounting their experiences. Some preferred to answer questions to help them get started while others had prepared exactly what they wished to say and were content to start themselves. People often wanted to know how long their meeting would last. The answer always given was that the meeting would last as long as they needed it to last. The time allocated to them was for them to use as they wished. A review of all the meetings reveals that an hour and a half was the average time taken for a meeting with the

Forum. Some meetings lasted for a shorter period and some for much longer. All meetings proceeded constructively and according to the wishes of the applicant. Occasionally panel members suggested to an applicant that he or she should take a break, for example when he or she became distressed in recounting experiences or was becoming tired. Some availed of that opportunity, others declined saying that they wanted to recount their information as quickly as possible; "to get it over as soon as I can" was the comment of one applicant. Others asked for a break to have a cigarette or requested a comfort break.

13 The Forum meetings were focused on the individual and his or her experiences and on no-one else. This required the Forum members to be understanding and acknowledge any distress or upset that arose on the day as painful life experiences were recounted. Forum members reassured applicants that any distress was respected and not unexpected. The Forum members' concern for the well-being of the applicant was at the heart of the process.

The Conclusion of Forum Meetings

14 When the applicants were satisfied they had recounted their experiences as fully as they would like, the meeting ended. In some cases the applicant indicated at that point that he or she still had other experiences in care to recount; when that occurred, an offer was made of a further meeting with the Forum members. Applicants were also told that, as an alternative, they could send additional recollections in writing, in confidence, to the Forum members with whom they had met. When a meeting was clearly at an end, the Forum members thanked the applicant and the applicant's WSO would come to the room and sit with them and ensure that they had time to relax before leaving to go home. The WSOs ensured that the applicants were aware of the support services that could be accessed – in addition to any they had availed of already. Any questions relating to travel or other expenses incurred in attending the meetings were answered at that time.

15 In the week following the applicant's meetings with the Forum, their WSO, with their prior permission, phoned to ask how they were and to follow up on any queries they may have had or that had arisen since their meetings with the Forum.

Acknowledgement of the Age and Health of Applicants

16 The Inquiry related to designated establishments that functioned at some stage during the period from 1922 to 1995. Given that time span, Forum members were alert to both age and health issues that might arise for some applicants. Consequently, priority was given to those whose needs required an early appointment. Inevitably this meant, in practice, that it was not possible to say exactly how long an applicant would have to wait for an appointment. However, Forum members were very conscious of the commitment applicants made when they completed application forms and they worked to see each person as soon as possible. Applicants, for the most part, understood and accepted this.

Chapter 2:

Chapter 2: The People Who Applied

Informing Former Residents about the Inquiry

1 Information about the Inquiry was available from a number of sources including the NI Assembly, the Inquiry itself – through its strategy to ensure that as many former residents as possible were made aware of its work and the ways in which individuals should apply to participate – and widespread coverage in news media, both locally and further afield.

The Applicants' Eligibility to Participate in the Inquiry

2 Applications to be included in the Inquiry were received from 533 people. When the applications were reviewed against the Inquiry's Terms of Reference it was found that 32 had been placed in or had attended establishments that were outside the Terms of Reference and so were ineligible for participation. Another seven applications were duplicates of applications already received and 37 applicants later withdrew their applications or their applications were designated as withdrawn by the Inquiry. In the latter case those applicants had:

- failed to attend on at least three occasions for meetings with the Forum; or
- failed to respond to numerous attempts by the WSOs to contact them to arrange a meeting with the Forum or Statutory Inquiry or provide requested information.

3 The Forum began to meet applicants in October 2012. By November 2014, the Forum members had listened to the experiences of 427 people who had been cared for in designated establishments in Northern Ireland between 1922 and 1995. One applicant's written account was also accepted, bringing the total number to engage with the Forum to 428.

The Applicants Who Attended the Forum

4 The great majority of applicants who met the Forum were born in Northern Ireland. Others were born in the Republic of Ireland, England, Scotland, South Africa and the USA. The figures for each country are given in the following table.

Country of birth	Male	Female
Northern Ireland	224	134
Republic of Ireland	15	17
England and Wales	11	10
Scotland	2	2
South Africa	2	-
USA	1	-
Undisclosed	7	3
Total	**262**	**166**

There was a wide age range amongst applicants. The numbers born in each decade varied with the largest numbers coming forward from the 1940s, 1950s and 1960s. This information is set out in the table below.

Decade of birth	Male	Female	Age in 2012
1920 - 1929	3	1	83+
1930 - 1939	20	13	73+
1940 - 1949	51	37	63+
1950 - 1959	79	56	53+
1960 - 1969	78	39	43+
1970 - 1979	27	17	33+
1980 onwards	4	3	32 or under
Total	**262**	**166**	

Reasons for Coming Forward

5 The 427 applicants who engaged directly with the Forum gave one or more reasons for doing so. Two reasons were mentioned more than any others: "to tell my story" and "to record abuse." Those who said they wanted to tell their story indicated that they wanted to be listened to, to be heard without interruption, challenge or disbelief. "Please listen to all I have to say", "I've waited so long to do this", "I thought the day would never come" and "I'm so grateful for the opportunity to be heard" were typical of the comments made by applicants. Others said that they wanted to have it on the record that they had been abused, even where they did not want to take the matter any further.

6 Other reasons given by both men and women included the wish to help others and help to prevent abuse. Some said they hoped that by coming forward they would both encourage others who had had similar experiences to do so and, where those others were still not able to report their abuse, to give them a sense that what they had experienced was being represented to authority. Almost a fifth of the applicants regarded participation in the Forum as a therapeutic experience and part of the healing process they were engaged in as they strove to deal with their past abusive experiences in residential childcare.

7 A small number, around 7%, said that they had been persuaded by others to come forward. Their reluctance to do so of their own volition, they said, reflected a number of factors including their lack of self-confidence, their sense of awkwardness and mistrust in dealing with authority, and their perception that they would not be believed.

8 The selection of quotations that follows exemplifies these concerns and other feelings that applicants expressed in coming to the Forum.

Males

"I wanted to meet you and share the burden I've carried for so long."

"This is a dark secret I kept hidden until three years ago. After I had a breakdown I started to talk about it…It's important that I tell all of my story…I want to be believed."

"I found it difficult to come to the Forum and made a number of dummy runs…I see the Forum as part of the healing process along with the counselling I've been having for four years."

"I find it very difficult to talk about the sexual abuse I endured, but I need to be heard and believed after a life of denial and rejection."

"I want to put this nightmare in its place. I just want to get this fucking anger out of me."

"I feel my abusers have not been dealt with properly and have largely escaped any accountability."

"I'm really grateful for this opportunity to unburden myself."

"I believe I have to inform future generations of what happened to child migrants."

"I want and need to be believed. I have not spoken about my abuse since I left Northern Ireland when I was fourteen."

"I have waited for a long time for this opportunity to be heard and believed…I want my experiences on the record…I have had serious mental health problems over the years and I believe they're the result of being abused when I was a child."

"I saw the HIAI posters and felt I had a duty to back up the testimony of anyone else who'd come forward."

"I'm not interested in compensation – my interest is to help the children in care today."

Females

"My prime concern is to ensure that what happened to me couldn't happen to any other child."

"I want my story to be told to help future generations."

"It's nice to get it off my chest; that's the most I have ever said to anybody."

"I want to tell my story but now I want to keep it dead, at the back of my mind, and just get on with my life."

"At last I've got someone to listen to me."

"I just want to be believed. In the past, people tried to tell but they weren't listened to."

"I reported my abuse on a number of occasions but my complaints were ignored."

"I feel guilty that I did not come forward earlier with information which might have made a difference to someone else."

"My doctor advised me to talk to the Inquiry as part of his way of getting me to confront the past and deal with it."

"I was contacted initially some time ago by an ex-resident and I decided to join the action being taken by the group."

"I've been struggling for a long time with whether or not to come to the Inquiry but I finally agreed…I want to speak on my behalf and on behalf of the others that I saw being abused…I want to tell all I can without being challenged."

"I feel very wronged that my culture and heritage were stolen from me when I was sent to Australia."

"I feel very strongly that the most disadvantaged children were not cared for appropriately."

9 The reasons for coming forward are summarised in the table below.

Reasons	Male	Female	Total
To tell my story	150	104	254
To record abuse	146	83	229
To help others/prevent abuse	57	30	87
Therapy (part of the healing process)	56	27	83
Sense of obligation	33	12	45
Persuaded by others	20	11	31
Other reasons	27	13	40
Total			**769**

Note: Many applicants gave more than one reason for coming forward, hence the figures above when totalled exceed the number of applicants.

Location of Meetings with Applicants

10 Applicants came from all over the United Kingdom and beyond to attend the Forum: 64 per cent from NI, 16 per cent from England and Wales, 1 per cent from Scotland, 5 per cent from the Republic of Ireland, 1 per cent from other parts of Europe, 12 per cent from Australia, and 1 per cent from the rest of the world. Some, for reasons of health or factors such as distance from the Inquiry's premises, were heard in or close to their home.

Location of Forum meetings	Applicants
HIAI premises	278
Derry/Londonderry	61
Other places in NI (1 care facility, 1 hospice and 1 health facility)	3
Applicant's or relative's home (including 8 in England and 1 in Wales)	14
Perth, Australia	29
Melbourne, Australia	4
Brisbane, Australia	2
Republic of Ireland	4
England	16
Scotland	1
Prison, including 4 in England	11
Secure NHS hospital in England	1

Location of Forum meetings	Applicants
Phone calls to Canada, USA and Australia	3
Total	**427***

*** Note:** As mentioned earlier, one applicant's written account of his experiences in childcare in NI was also accepted by the Inquiry bringing the total number of applicants who met or had contact with the Forum to 428. That total is used throughout the remainder of this report.

Social and Demographic Profile of the Applicants

11 This section of the report provides an overview of the personal details of 262 male and 166 female applicants who gave information to the Forum. The demographic information compiled in the following section was provided by the applicants in regard to their pre-admission social and familial circumstances. Some applicants had no knowledge of their parents or chose not to speak of them at their meeting with the Forum. Information on fathers was most likely to be missing.

12 The table that follows shows that the majority of applicants understood that their parents were married at the time of their birth. The next largest group were born to single mothers, who often were unable to rear their children alone, whether because of the stigma attached to single parents or because of a lack of resources.

A total of 65 applicants had no knowledge concerning their parent's/ parents' marital status or chose not to speak about that.

Marital status of parents	Male	Female	Total
Married	137	79	216
Divorced	7	2	9
Single	52	37	89
Separated	8	3	11
Extra-marital	11	9	20
Co-habiting	6	10	16
Widowed	1	-	1
Not known	40	26	66
Total	**262**	**166**	**428**

Main Issues in Parental Relationships Affecting Applicants' Admission to Care

13 Outlined below are the main issues that male and female applicants identified as occurring in their parents' relationship and which affected decisions about their upbringing. The issues include death of one or both parents, abandonment by one or both parents, domestic violence and emotional abuse in the family, imprisonment of one or both parents, mental health difficulties and substance misuse, including, alcohol abuse.

Death of Parents

- 114 female applicants said their mother was deceased. Twelve of those deaths occurred when the applicant was very young.
- 87 females said their fathers were deceased. One of those deaths occurred when the applicant was very young.
- 158 male applicants said their mother was deceased.
- 28 of those deaths occurred when the applicant was very young.
- 115 males said their fathers were deceased. Four of those deaths occurred when the applicants were very young.

Abandoned by Parents

- 74 female applicants said their mother abandoned them.
- 55 females said their father abandoned them.
- 84 male applicants said their mother abandoned them.
- 78 males said their father abandoned them.

Domestic Violence in the Family

- 37 females said there was domestic violence in their family.
- 53 males said there was domestic violence in their family.

Emotional Abuse in the Family

- 40 females said there was emotional abuse in their family.
- 59 males said there was emotional abuse in the family.

Imprisonment of One or Both Parents

- Six females said their mother had been in prison on one occasion or more.
- Twelve females said their father had been in prison on one occasion or more.

- One male said his mother had been in prison on one occasion or more.
- Ten males said their father had been in prison on one occasion or more.

Mental Health Difficulties

- 30 females said their mothers had experienced mental health difficulties.
- 35 females said their fathers had experienced mental health difficulties.
- 30 males said their mothers had experienced mental health difficulties.
- Ten males said their fathers had experienced mental health difficulties.

Substance Abuse including Alcohol Abuse

- 49 females said their mothers had been involved in substance misuse and/or alcohol abuse over a number of years.
- 36 females said their fathers had been involved in substance misuse and/or alcohol abuse over a number of years.
- 42 males said their mothers had been involved in substance abuse and/or alcohol abuse over a number of years.
- 68 males said their fathers had been involved in substance misuse and/or alcohol abuse over a number of years.

14 The following selection of quotations and comments from applicants has been chosen to illustrate some of the issues commented on.

> "My mother died of tuberculosis. There were six children all very young. My father left us alone to go to work, so we were put into care."
>
> "My parents were in a mixed marriage in which my father's views prevailed. My mother had been married before and had two daughters from that marriage. Mother died, when I was two, from cancer. My mother's sisters offered to bring us up but my father wanted us brought up in his religion so refused this offer. Father didn't want us adopted so he paid for us to stay in an institution."
>
> "My father was alcoholic and we were a big family. I loved my mother; I was the apple of her eye. I was chastised by my father for getting into trouble but at least he was beating me for doing something…they beat me for nothing."

"I was born in hospital and when my mother returned with me, her mother refused to allow her into the family home. I was placed with my uncle…who cared for me until I was five months old and I was then placed in care."

"Both my parents had chronic alcohol problems over many years. My father was very violent, and my mother was very frightened of him."

"My father was just seventeen and my mother 23 when they married. They eloped to London, and later both developed alcohol problems."

"My mother and father were prosecuted for neglect and served three-month sentences for this."

"My mother suffered from chronic depression, and my father, who was violent, from poor health. We had a nomadic existence, and rented houses always of a very low standard."

"My parents were in a mixed marriage and both families disapproved. They went to England where I was born. My parents moved back but my mother died of lung cancer. My father tried to cope but eventually couldn't cope."

"My parents both drank a lot and there were a lot of alcohol-fuelled fights between them."

"My parents were in a mixed marriage…The extended families on both sides, including grandparents, disowned me, my parents and my siblings so I had no contact with my extended family."

"I came from a big family, thirteen in total; some of the children were born as a result of extramarital affairs. My father was a violent alcoholic."

"I think my parents' marriage was strong and successful. I was the black sheep of the family."

- An applicant described a home marked by domestic violence and the children in the family were sexually abused by the father.
- An applicant had virtually no information about his parents and said the staff in his establishment did not disclose any details of his background – even though he thinks they had information. He found out by chance that his mother had passed away.
- An applicant from the Travelling Community told the Forum that his parents were described as living in absolute poverty with no money to provide for their children.

Parents of Applicants - Occupational Status

15 The table below shows the occupational status or job description of the applicants' parents at the time of their admission into the care system. In two-parent households, the father's occupation is recorded and in other circumstances the occupational status of the sole parent is included. More than 50 per cent of applicants did not know the skill level of their parents at the time of their birth and a further 22 per cent reported that their parents were unskilled.

Occupational status	Male	Female	Total
Professional worker	4	2	6
Managerial and technical	1	1	2
Non-manual	1	1	2
Skilled manual	30	15	45
Semi-skilled	10	6	16
Unskilled	62	33	95
Unknown	154	108	262
Total	**262**	**166**	**428**

Siblings of Applicants

16 Of the 428 applicants, 336 reported that they had brothers and sisters, some or all of whom may also have been in the care system. The following table indicates approximate family size as reported by applicants.

Number of siblings	Number of Applicants
0	51
1 – 4	176
5 – 9	125
10 or more	35
Unknown	41
Total	**428**

17 One hundred and sixty applicants had five or more brothers and/or sisters. For the purpose of this report, half-brothers and sisters are included as siblings as they were described by applicants as family members. The average family size reported by the 336 applicants was five children.

Eighty-five applicants were deemed to be single children without siblings, having either stated that they knew they had no siblings or that they have never been able to establish the facts in relation to the details of their family of origin.

18 In allowing for families represented by more than one applicant to the Forum, the 428 applicants represent 306 families. Applicants who came to the Forum were mainly first-born children or the youngest member of the family.

Siblings of Applicants in the Care System

19 A total of 253 applicants reported having siblings in the care system. It is of note that many applicants to the Forum reported that, when they were received into care, older brothers and younger family members were likely to have remained within the extended family. A small number of applicants noted that older siblings who had been placed in designated establishments in Northern Ireland had been sent to Australia under the child migrant scheme.

20 Some applicants were raised with their siblings prior to their placement in care, while others were one of the younger members of the family and did not know their older brothers and/or sisters. Many applicants spoke to the Forum of their confusion, when discharged back to their family home, to find they had new brothers and sisters of whom they were unaware. Other applicants spoke of their deep distress at losing contact with siblings who lived in the same establishment as them but were separated because of policies on age and gender so that gradually the bonds of kinship were broken.

21 The following quotations and comments concerning siblings illustrate the information provided to the Forum.

> "If you haven't got family, you are a nobody. You know when someone in a family dies, you grieve for them; we were grieving all the time - but we didn't know what we were grieving for…I have nobody."
>
> "The care system split us up. We had no bond; now we are argumentative rather than close."
>
> "I was close to my two brothers. I always defended them. I have more scars for my brothers than for myself."
>
> "I felt guilty because I was taken out of the home and my two younger sisters were left behind…When mum collected me I wasn't allowed

to say goodbye to my sisters…I was taken out, I felt guilty just leaving them there…I felt terrible for my younger sisters all these years."

- An applicant told the Forum that her older sister and two brothers returned to their mother in England but she was left with a sister in a designated establishment. At twelve, she was flown to England with her sister to be returned to her mother's care and her mother was a complete stranger to both of them. Their mother had had two other children whilst they had been in care.
- An applicant told the Forum that she and her sisters were separated when they were received into the children's home. The older two sisters were denied contact with her. She recalled holding her sisters hands through railings separating the different parts of the establishment. She became emotional asking: "why wasn't I allowed to mingle with them; embrace and hold them?"

Chapter 3: The Applicants' Experiences How they are Presented in Chapters 4 and 5

1 Chapters 4 and 5 of this report are based entirely on what applicants told the Forum about their experiences in designated establishments. As noted earlier, the term designated establishment is used to signify an establishment that met the terms of reference of the Inquiry. Throughout the report the terms "children's home" and "home" are also used as synonymous with designated establishment because those were the terms most often used by applicants in their meetings with the Forum.

2 The information in these chapters is not tested evidence, nor is it the outcome of a series of structured interviews. Some participants were ready to recount their experiences without any prompts from the panel members; others, who were unsure about how to tell of their experiences, accepted the panel members' offer to help them get started by asking some introductory questions, usually focusing on what they knew of the reasons for their initial admission to care.

3 This part of the report is not an exhaustive series of quotations but rather comments based on what people said, supported and enlivened by a selection of quotations that reflect the voices of those who took part.

The information in Chapters 4 and 5 is arranged by period, establishment type and gender of applicant. The years spanned by the Inquiry – 1922 to 1995 – have been grouped into three periods:

- Period 1 – 1922 to 1955
- Period 2 – 1956 to 1975
- Period 3 – 1976 to 1995

These periods have been chosen to reflect significant changes in legislation and public policy in the care of looked after children in Northern Ireland.

4 The designated establishments in which applicants were resident as children have been grouped into three broad types:

- Voluntary
- State
- Juvenile Justice

5 Voluntary establishments were those provided and managed by voluntary institutions such as the main churches and charitable bodies. State

establishments were those provided by local welfare committees and other state agencies. Juvenile justice establishments were those in which the majority of the children and young people were placed further to coming through the juvenile justice system.

6 As explained above, the information given by applicants to the Forum in respect of each establishment type is organised by gender so, for example, in looking for information about the care experiences of females in juvenile justice establishments in the 1960s the reader should turn to Chapter 4, Period 2 and Females: juvenile justice.

7 Some applicants' placements in designated establishments began in the later stages of one period and continued into the early stages of the next. In those cases their experiences are included in the period in which they spent the greater part of their placement. Other applicants who had more than one placement, with one in one period and another in the next, will have their experiences in each placement included in the period in which it occurred. These details are significant in that it is therefore not possible to simply add the numbers in certain tables in each period in the report and arrive at a number equivalent to the total number of applicants who met the Forum; such totals could be greater than the actual number of applicants, as some applicants had multiple placements.

8 Inevitably, in view of the variations in the extent and detail of the information given to the Forum and the panel members' commitment to reflect fairly the information given, there are differences in the focus and scope of some of the paragraphs and tables in each period in Chapters 4 and 5 of the report. For example, in Period 3, 1976 – 1995, a smaller proportion of applicants complained about fewer aspects of daily living experiences than those in Period 1, 1922 – 1955 and Period 2, 1956 – 1975; a reflection, perhaps, of changing standards and resources in residential childcare, over time, in Northern Ireland.

Chapter 4:

Period 3:

Chapter 4: Applicants' Experiences of Care

Period 1: 1922 – 1955

Introduction

1 Seventy-two applicants – 47 men and 25 women – who had been in residential care at some stage in their childhood in the period from 1922 to 1955 spoke to the Forum about their experiences. The oldest male applicant from this period was born in 1926 and the youngest in 1953. The oldest female applicant from this period was born in 1927 and the youngest was born in 1949.

2 Thirty-two of the applicants – 21 men and eleven women – had been sent from six voluntary establishments in Northern Ireland to Australia under the child migrant scheme. Only their experiences in designated children's residential establishments in Northern Ireland are included in this report. Thirty-eight of the applicants, 24 men and fourteen women, entered the care system between 1939 and 1945, the years of the Second World War.

Placements in the Care System

3 The number of establishments by type in which applicants had lived is summarised in the following table; the numbers of applicants who had been placed in each type of provision are also included.

Applicants in Each Category of Provision			
Establishment type	**Gender**	**Number of Establishments**	**Number of Placements**
Voluntary	**Male**	7	43
	Female	8	24
State	**Male**	6	6
	Female	1	1
Juvenile Justice	**Male**	1	2
	Female	-	-

4 Almost twice as many men as women who had been in a designated establishment in Period 1 came to the Forum. At the time they applied to the Inquiry they ranged in age from 83 years to 69 years.

The table below sets out the age range of those who applied.

Applicants/age range	60 to 69 years of age	70 to 79 years of age	80 to 89 years of age	All Applicants
Males	11	29	7	47
Females	10	10	5	25
All applicants	**21**	**39**	**12**	**72**

5 Most of the men and women in Period 1 had been placed initially in establishments that were part of the voluntary sector, the majority of them under Roman Catholic management. These establishments were large, accommodating up to 150 children. Those who had been in state care had lived in smaller establishments with provision for as few as ten children. One applicant had been in a specialist residential home for children with hearing, speech and sight disabilities and two others had had a placement in a juvenile justice establishment – a training school. Another had been in a workhouse with his mother and brother and he was cared for in that setting for some years.

Circumstances of Admission into the Care System

6 Some applicants described in detail the circumstances that led to their being placed in children's residential care. Others spoke, as far as they could, about their childhood circumstances but some, despite persistent research, still had little information about their parents and wider family circle. They spoke of a longing – a gap to be filled – to know more about their families, and some were still deeply affected by the lack of information about their family backgrounds.

Order of Admission to Care

7 For the great majority of applicants in Period 1, their first placement was to be their only placement in designated establishments. A few applicants had previously been in foster care and so their admissions to designated establishments are included in the following table as second admissions.

Order of Admission to Care					
Establishment Type	**Gender**	**First**	**Second**	**Not known**	**Total**
Voluntary	**Male**	33	5	1	39
	Female	21	3	-	24
State	**Male**	5	1	-	6
	Female	1	-	-	1
Juvenile Justice	**Male**	-	2	-	2
	Female	-	-	-	-
Total		60	11	1	72

Age at Entry to the Care System

8 The ages of the applicants when first admitted to a designated establishment ranged widely. Of note is the fact that half of both the men and the women had been admitted as very young children, ie two years of age or younger.

Age at Entry														
Establish-ment	**Gender**	**<1**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**10+**	**Total**
Voluntary	**Male**	12	4	7	2	4	4	2	3	1	-	-	2	41
	Female	7	2	2	1	2	5	2	1	2	-	-	-	24
State	**Male**	1	-	1	-	1	-	-	1	-	-	1	1	6
	Female	-	-	-	-	-	1	-	-	-	-	-	-	1
Juvenile Justice*	**Male**	-	-	-	-	-	-	-	-	-	-	-	-	-
	Female	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		**20**	**6**	**10**	**3**	**7**	**10**	**4**	**5**	**3**		**1**	**3**	**72**

Note: There are no entries in the juvenile justice section because for the two applicants who had placements in a juvenile justice establishment those placements were not their first admission to care.

Duration of Placements in the Care System

9 A review of the duration of placement in the various types of establishment indicates that two thirds of the applicants spent five or more years of their childhood in at least one establishment and almost a fifth of them had been in establishments for ten or more years in Northern Ireland. The table below presents this information by establishment type and gender.

Duration in Years																	
Establishment	**Gender**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
Voluntary	**Male**	1	4	4	5	2	4	4	4	7	4	3	-	-	-	-	1
	Female	2	-	1	1	4	4	5		1	3	1	1	-	1	-	-
State	**Male**	4	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-
	Female	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Juvenile Justice	**Male**	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-
	Female	-	-	-	-	-	-	-	-	-		-	-	-	-	-	-
Total		**8**	**6**	**5**	**6**	**7**	**8**	**10**	**4**	**8**	**7**	**4**	**1**		**1**		**1**

Note: The figures indicate placements, not applicants.

Age at Discharge from the Care System

10 Some applicants were sent from their residential establishments back into their family homes. Others were fostered and some, at the age of fourteen and older, were placed in work, in a few cases in the establishment in which they had been living. An analysis of their ages at discharge from the care system and the establishment type from which they were discharged is given in the table below.

Age at Discharge																		
Establish-ment	**Gender**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**Total**
Voluntary	**Male**	-	1	1	2	4	2		10	6	2	2	2	2	2	4	1	41
	Female	1	-	1	1	5	1	1	1	2	1	-	2	4	2	2	-	24
State	**Male**	1	-	1	-	-	1	1	-	1	-	-	-	-	-	-	-	5
	Female	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1
Juvenile Justice	**Male**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1
	Female	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		**2**	**1**	**3**	**3**	**9**	**5**	**2**	**11**	**9**	**3**	**2**	**4**	**6**	**4**	**7**	**1**	**72**

Applicants in each Type of Provision

11 The great majority of applicants in this period, 69, had one placement in a designated establishment but three had more than one. Two applicants, both men, each had two placements and one man had been in three establishments. The table below summarises this information.

Establishment	Male	Female	Total
Voluntary	43	24	67
State	6	1	7
Juvenile Justice	2	-	2
All	**51**	**25**	**76***

Note: The figures indicate placements, not applicants.

Referral Sources/Agencies

12 The circumstances that led to their placement in designated establishments were remembered by almost a third of the applicants. Nine of the men who had been placed in voluntary establishments spoke about family members seeking the assistance of the Church in having them placed in care. In a few cases, this was an outcome of a family's wish to conceal the birth of a child born out of wedlock; in others it reflected an unmarried mother's struggle to maintain her child in the absence of family and other support. Some placements were arranged by Church authorities because of concern for the welfare and mental health of the mother or both parents. Five of the male applicants knew that there had been an intervention by two or more authorities that led to their being placed in designated establishments. For example, one man said that the local clergyman had taken him and his foster brother to an establishment where they were visited every three months by a welfare officer. Another man spoke of the police and welfare services intervening and, with the assistance of the Church, arranging for him to be placed in an establishment. One applicant was in a state establishment with his mother and remained there for some years before being fostered.

13 The circumstances relating to the referral of the female applicants in this period mirrored those of the males, although a higher proportion of them were referred by family members with the involvement of the Church. Two of them were placed in care by the order of a court. A summary of the referral sources, where known, is given below.

Referral Source/Agency	Male	Female
Welfare Authorities	4	1
Clergy/Religious Orders	6	3
Courts	-	1
Police and Welfare	3	-
Family	3	2
Family and Church	-	2
Probation/Education Board	-	1
Not known	**31**	**15**

14 Earlier it was noted that three of the men had been in two or more establishments. One applicant as he grew older transferred from a voluntary establishment that catered for children up to eleven years of age to another that accommodated older children. Another applicant transferred from a voluntary establishment to a juvenile justice establishment and the third applicant moved from a state establishment to a juvenile justice establishment into a voluntary establishment. In the latter case the initial placement had been a temporary measure whilst decisions were taken about longer term placement options.

Reasons for Admission to Care

Males: Voluntary Sector

15 Many of the male applicants had been born to unmarried mothers who found it very difficult to raise their children because, as applicants told the Forum, of lack of financial and family support and negative societal attitudes. Most of these applicants had very little information about their birth mother or maternal family, despite some saying they had searched exhaustively for it.

16 Several of the five male applicants whose parents had died when they were children said there was no one within the family network who was able or willing to care for them. One applicant, who was part of a large sibling group, said that his mother had died in childbirth, his father was away in the Army and he and his siblings went to live with their grandmother. Their grandmother was unable to cope and the children were placed in several designated establishments. One applicant said his parents died within six months of each other and there was no one able to care for him. Two

male applicants were placed in designated establishments as their foster mothers had died. The reasons given for admission are summarised in the following table.

Reasons for Admission	
Parents Unable to Cope	24
Abandonment	8
Court Order	-
Parents Deceased	5
Unknown	4
Total	**41**

Males: State Sector

17 Male applicants in state establishments were placed there for reasons similar to those of their contemporaries in the voluntary establishments. Two male applicants referred to their parents being unable to cope, with one commenting that his mother was experiencing mental health difficulties. Two other applicants said that their parents were deceased. One of these applicants was in his placement in a designated establishment for a very short period of time as it was planned that he would move to a long-term foster placement. Two male applicants chose not to comment on or did not know the reasons for their admittance into residential care.

Reasons for Admission	
Parents Unable to Cope	2
Abandonment	-
Court Order	-
Parents Deceased	2
Unknown	2
Total	**6**

Males: Juvenile Justice Provision

18 One of two applicants had been cared for initially in a state establishment and was moved from there to a juvenile justice establishment. Subsequently

he was transferred to a voluntary establishment from which, eventually, he was discharged from care. The other had been placed initially in a voluntary establishment and, as a result of absconding, was transferred to a juvenile justice establishment from which he was discharged from care.

Females: Voluntary Sector

19 Female applicants who were in voluntary establishments during Period 1 gave reasons similar to those of the male applicants for having been placed in those establishments. Most of them said their parents were unable to cope and this resulted in their reception into care. The table that follows lists the reasons given for admission.

Reasons for Admission	
Parents Unable to Cope	13
Abandonment	8
Court Order	2
Unknown	1
Total	**24**

20 Eight female applicants, who told the Forum that they had been abandoned, referred to being born to unmarried mothers. Some of the female applicants commented that they had very little information about their birth mothers or maternal families with some speaking of their sadness and frustration that having tried as adults to get information, they had not been successful.

21 Three female applicants said their mothers had died and there were no others in their family networks willing or able to care for them. Three female applicants said that their mothers had been unwell, including one whose mother had a physical disability and another whose mother suffered from mental and emotional ill-health.

22 One applicant said she was removed from her family because of homelessness; her parents could not afford to pay the rent and the family "were literally thrown out into the street." One applicant said that she thought she was taken into care as her parents had an alcohol addiction and the children in the family were being neglected. Two female applicants said they were taken into care under a court order. One of these applicants had special needs and had not been attending school. The other recalled her mother bathing her, along with her siblings, in preparation for their

removal by welfare officers from the family home. This female applicant said, with sadness, that her mother wrote her a letter years later in which she said she felt as though she had "locked her children out" and she had an enormous sense of guilt for handing them over to officials.

Females: State Sector

23 The only female applicant placed in a state establishment was admitted into care with her sibling as her mother had died and her father was unable to care for his children.

Memories of Admission: Male and Female Applicants

24 Few of the men and women in Period 1 have memories of the day of their admission to a children's home as many of them were babies or very young children when that occurred. What they now have learned about the circumstances of their admission is the outcome of access to their personal records, other records held by the designated establishments and contacts later in life with family members and family friends and neighbours. However, as noted earlier, some had been unable to gather such information and remain uninformed about their childhood circumstances.

Aspects of Care in the Residential Establishments

25 The experiences of the 47 male applicants and of the 25 female applicants, who were in designated establishments during Period 1, are set out in this section of the report under voluntary sector provision, state sector provision and juvenile justice provision categories. Applicants' accounts are described by gender within the three types of provision. Applicants' accounts of the five general care conditions of food, clothing, heat, bedding and personal care are included in this section. Where any of these experiences are described as abusive or neglectful, this information is included in the abuse/neglect section of this report.

26 The first part of this section covers the reports made by 41 male applicants who had a total of 43 placements in seven individual voluntary establishments. The second part of this section covers the experiences of 24 female applicants who had a total of 24 placements in eight voluntary establishments.

Males: Voluntary Provision

27 Approximately half of the 41 male applicants who had been placed in voluntary establishments recalled their experiences of day-to-day living in children's homes. Their opinions of their care conditions are set out in the following paragraphs.

Diet

28 Twenty of the applicants commented on the food they had been given. The consensus was that the food was adequate or poor and some of them remember being hungry all the time. Types of food mentioned included porridge:

> "in a bowl with salt poured into a hole in the middle of the serving, bread and dripping for breakfast," and "very fat meat for lunch."

One applicant said that he "was not fed well, just scraps; I thought jam was a luxury. We got an apple and orange at Christmas." On the other hand, two applicants spoke appreciatively of the food served. Another said

> "Times were hard during the war and the staff did their best for the children" and the other said he "was grateful for the care after the neglect at home."

Diet	Voluntary
Male	
Good	-
Adequate	12
Poor	8
Very Poor	-
Not Disclosed/No Memory	21
Total	**41**

Clothing

29 Twenty-one male applicants made reference to the clothing they were given in voluntary establishments. For the most part they were not critical of the clothes provided. One applicant spoke about being given ill-fitting clothes and said that "the underpants were often too small; when I got a pair that fitted it was bliss." Another reflecting back on the clothes provided said that as soon as he was discharged he got a new suit made. He felt he was shaking off the old and putting on the new.

Clothing	Voluntary
Male	
Very Good	-
Good	-
Adequate	10
Poor	9
Very Poor	2
Not Disclosed/No Memory	20
Total	**41**

Personal care

30 Male applicants gave little detail about their personal care. The general view was that the personal care provided was adequate or poor. Some described shared baths and shared bathwater with Jeyes Fluid in the water causing discomfort to their skin. They objected to the fact that by the time they got to the bath, the water was dirty. Others commented on the lack of privacy at bath time and having to stand, undressed, in a line waiting for a bath. One of the men recalled having his hair cut when he was four; he told how he was held down in a chair and because he did not know what was going to happen, he struggled against those holding him down and received a cut from the scissors as a consequence. The male applicants' opinions of their personal care is summarised in the following table.

Personal Care	Voluntary
Male	
Good	-
Adequate	11
Poor	10
Very Poor	2
Not Disclosed/No Memory	18
Total	**41**

Bedding

31 None of the male applicants made detailed comments about the beds or bedding in their children's homes. Generally, those who made any reference to bedding were at least satisfied with the comfort and warmth of their beds and spoke more about the dormitory, bathroom and toilet arrangements and supervision during the night. Some referred to older boys being in charge and supervising the dormitories; others spoke of a nun having sleeping accommodation in an adjoining room or "cell" with a curtained window through which she could monitor the children when they were in bed.

Bedding	Voluntary
Male	
Very Good	-
Good	-
Adequate	13
Poor	4
Very Poor	-
Not Disclosed/No Memory	24
Total	41

Heating

32 In summary, and apart from two references to good heating, most of the sixteen men who commented on this aspect of their care thought the heating was adequate or poor; "of its time" was a view shared by a few. Their opinions of this aspect of their care are set out in the following table.

Heating	Voluntary
Male	
Very Good	-
Good	2
Adequate	9
Poor	3
Very Poor	2
Not Disclosed/No Memory	25
Total	**41**

Work in the Voluntary Establishments

33 The men's memories of work in their voluntary establishments were consistent with those of the women who came forward. They had a range of daily duties including bed-making and helping clear tables after meals. Twenty-four of them (more than half) referred to tasks that they regarded as work that had to be done on a regular, usually weekly, basis. For most of them, these tasks included scrubbing and applying polish to, and buffing, floors. One man said that he and his friends had to polish wooden doors, wainscoting in the corridors and wooden staircases. He said they also had to clean and polish floors in the chapel, the dining rooms, the study halls, the kitchen and the lavatories. Some said much of the floor work had to be done on their hands and knees and others referred to buffing the floors with cloths tied to their feet. It was reported that, in one establishment, groups of boys linked arms and shuffled down long corridors, polishing as they progressed. Several referred to a chant they said when polishing floors

"River and back, river and back; I'll put the broom across your back"

a chant that related to the nearby river and the punishment that could be meted out if the pace of work slackened. It was reported that this cleaning work was carried out on Saturdays for the most part, all year round. A few referred to additional cleaning having to be done, usually linked to expected special visitors and events.

34 Some of the men said that, in season, they had been given work to do on neighbouring farms. For example, some had potato-picking duties; others had been asked to help cut field grass for hay-making using scythes. They said they had to work "from morning to night" and received "nothing in return."

Religious Practice

35 Religious practice was an integral part of the daily routine for those applicants in Period 1 who had been cared for in voluntary, church-run, establishments. From what 30 of the male applicants related, it was evident that the day and the average week were punctuated and infused with religious observance and teaching that included:

- prayers each morning before breakfast and in the evening
- prayers before and after lessons in school
- religious education at school

- mass at regular intervals, for some on a daily basis
- confession.

36 A few of the men spoke with fondness of having been selected to serve as altar boys and of the affirmation they took from this. Others spoke about the enjoyment they experienced from singing in the church. Several men said they were able to recite the Benediction in Latin as the boys learnt this in parrot fashion – even though, as one man said, they did not always know what it meant. This man was also in the choir and spoke with real warmth about the nun who trained and conducted the choir; other male applicants spoke equally appreciatively of the same member of staff.

37 Generally, those men who recalled aspects of religious practice did not complain about it. Eleven of the applicants in Period 1 said that they had no memories of religious practice in their establishments. That group included a number of those who had been sent to Australia as young children.

Play and Recreation

38 When talking about their childhoods in care, two thirds of the applicants had no memory of any play-time or recreation. Some had no recollection because they were so young when they left their children's homes, for example to return to family or foster care, or, in other cases to travel to Australia. Others said emphatically there was no playtime or recreation.

39 The average day, as reported by a number of the applicants, was filled with religious practice, domestic duties and schooling. Many of them talked about the absence of toys and the lack of books. One said that in his establishment there were some books but the children were not allowed to read them. Several applicants referred to the extent to which they had to remain quiet and still when children of their age would have been playing indoors and out.

40 Five of the men remembered playing outside in big fields. They said they played football and other games and often had no proper footwear; if boots were too big they "had to stuff them with straw to make them stay on." Some of these men also enjoyed climbing trees in the grounds of the establishment and two spoke of an outside playground where they could run and play. Others who were in designated establishments in the latter part of Period 1 mentioned watching TV from 5.00pm to 6.00pm each night of the week. One man said that he had acted in a play and that

was a good memory; he also sang in the choir and the choir took part in the Belfast Feis. Another said that he was taught Irish dancing and was a member of the band where he learned to play the double bass. There was mention of a wind-up gramophone, and someone who had been in one of the voluntary establishments in the later part of this period talked about films being shown on Thursdays. Two of the men recalled days out to Millisle and eating ice cream at the beach.

Medical Care

41 Less than half of the male applicants recalled having received medical care during their placement in designated establishments. A summary of the nature of the medical care cited is shown in the following table.

Medical Attention	Voluntary Male
Infirmary	1
Medical Inspection	1
Immunisation	2
GP	1
Designated Medical Person	2
Dentist	5
Hospital	2
Nurse	5

Applicants' Experiences of Discharge from the Care System

42 Twenty-one of the men who had been in voluntary establishments in Period 1 were sent to Australia. Their memories of leaving care in Northern Ireland focused on what they remember of being told about going to Australia and of some aspects of the process and preparation, including being taken out to get new clothes for the journey and the new country.

43 The twenty male applicants who, as children, had been discharged from care in Northern Ireland summarised their experiences as follows:

- Three were transferred to foster care.
- Five were placed with farming families. Most of them had been put to work on the farm, generally for very long hours every day of the week including Sunday. One said "I worked from 6.00am to 10.00pm daily

in return for basic board and lodging. I had no opportunity to make friends and develop socially." Another described a similar routine; he had been sent to a farmer when he was fourteen. He said the work was heavy but "at least the farmer's son was working alongside me." The farmer's son left and the applicant was left to do the work of two people. After some time, the farmer took him back to the establishment and told the staff he was not working hard enough.

- Three returned to their families.
- Two were accommodated locally, in one case in a hostel and in the other in digs, and given jobs in Belfast, one as a van boy, the other in a furniture factory.
- Two were given work in establishments run by the same religious order as that in charge of their former establishments.
- The other five applicants did not provide information about their experiences of discharge from care.

Post-Care Support

44 Six of the male applicants who had been in voluntary establishments and who left care in Northern Ireland, told the Forum that jobs and lodgings had been arranged for them. Two of those men recalled that they were also given new clothes on discharge. One of the men was given a job in maintenance in another children's establishment provided by the same religious order in the Republic of Ireland.

Females: Voluntary Provision

45 Just over half of the 24 female applicants who had been in voluntary establishments in this period had little or no detailed memory of the accommodation and aspects of the care they had experienced; as one said

"I remember experiences and incidents more than the everyday things."

Some of those who had no recollection of food, clothing, sleeping accommodation and so forth, had been sent as child migrants to Australia from six of the voluntary establishments when they were as young as five. Their recollections, as with those of their male counterparts, relate more to the experience of being chosen to go to Australia and the journey and their care in that country.

Diet

46 Fourteen of the female applicants commented on the food they had been given. The consensus was that the food was adequate or poor and some

of them remember being hungry and, in season, stealing apples from a neighbouring orchard to fend off their hunger.

The following table summarises their views.

Diet	Voluntary Female
Good	-
Adequate	9
Poor	5
Very Poor	-
Not Disclosed/No Memory	10
Total	**24**

Clothing

47 Thirteen of the female applicants made specific reference to their clothing when in establishments suggesting that it was basic; some garments were second or third hand and some, such as pinafores and underwear, were made on the premises. School uniform was mentioned by one woman who said that it was uncomfortable because the cloth used – serge – was very stiff. Their views are summarised below.

Clothing	Voluntary Female
Very Good	-
Good	-
Adequate	8
Poor	4
Very Poor	1
Not Disclosed/No Memory	11
Total	**24**

Personal Care

48 Only a few female applicants spoke of the personal care in their establishment. Some applicants described baths with Jeyes fluid causing discomfort to their skin, some commented on the lack of toothpaste and others on the absence of toiletries unless their families brought some in for them. As one woman pointed out, that arrangement meant that some children never had basic toiletries while others did, thus adding another form of differentiation between the children. Their opinions about their personal care are summarised in the following table.

Personal Care	Voluntary Female
Very Good	-
Good	-
Adequate	6
Poor	4
Very Poor	4
Not Disclosed/No Memory	10
Total	**24**

Bedding

49 Just over half of the female applicants made comments about the bedding. Generally they were at least satisfied with the comfort and warmth of their beds. The following table represents the range of their views.

Bedding	Voluntary Female
Very Good	-
Good	1
Adequate	8
Poor	2
Very Poor	2
Not Disclosed/No Memory	11
Total	**24**

Heating

50 Ten of the female applicants commented on the heating in their establishment. Their opinions were favourable, in the main, with just two recalling being very cold. Their opinions are summarised in the following table.

Heating	Voluntary Female
Very Good	-
Good	1
Adequate	7
Poor	-
Very Poor	2
Not Disclosed/No Memory	14
Total	**24**

In summary, and apart from one reference to good heating and one reference to good bedding, most of the 24 female applicants who had been living in voluntary establishments, and who commented on this aspect of their care, thought their clothing, food, personal care and bedding were adequate.

Work in the Voluntary Establishments

51 The female applicants' memories of work in their establishments were similar to those of the men. In describing their daily routine in care, eleven of the 24 women spoke, often with strong feeling, about the work they were given on a regular basis – that is, in addition to the duties of bed-making, tidying their dormitories, clearing tables after meals and other tasks that were part of the daily routine of their time in residential establishments. The commonest form of work the applicants described was cleaning and polishing floors. Some referred to this as work that had to be done on Saturdays and described activities such as scrubbing floors, applying polish to wooden floors and buffing the floors to bring up a shine, as one said "until you could see your face in it." They said they were first given this work when they were seven or eight years old and they were required to do it for the duration of their placements. The work included responsibility for cleaning floors in long corridors, floors in accommodation used by staff and, for some, floors in the adjacent church.

52 Two female applicants said that when they were older they were given duties in the laundry. One of them added that she didn't mind this as "you were given bread and jam as you went along." Another female applicant said that, as a child in care, she had to prepare the bodies of the dead for burial. This involved helping to wash and dress the deceased, and putting pennies on their eye-lids. She had to do this in the "dead house" – a separate building nearby. The dead were those who had lived and had been cared for in a neighbouring residential care centre for older people.

Religious Practice

53 Religious practice was an integral part of the daily routine for both male and female applicants in Period 1 who had been cared for in voluntary, roman catholic, establishments. A third of the female applicants referred to daily and weekly religious observance and teaching that, as for the men, included:

- prayers each morning before breakfast and in the evening
- prayers before and after lessons in school
- religious education at school
- mass at regular intervals (for some, on a daily basis)
- confession.

Generally, those female applicants who referred to aspects of religious practice did not complain about it although one woman spoke with feeling about the discomfort in her knees after long periods of prayer, especially in Church on Sundays.

Play and Recreation

54 When talking about their experiences in establishments, two-thirds of the female applicants had no memory of any play-time or recreation. Some had no recall because they were so young when they left their establishments. Others said emphatically there was no playtime or recreation; one woman spoke of:

> "dark rooms and dark people with no encouragement for children to be themselves."

55 The average day, as reported by a number of the female applicants, was filled with religious practice, domestic duties and schooling. Many of them said they had no toys to play with; others commented on the absence of books. Several referred to the extent to which they had to remain quiet and still when children of their age would have been playing.

56 A female applicant spoke about having piano lessons and going to Irish dancing; another referred to one hour of play a day and a third said that girls of different ages played in different places in the establishment. Five applicants, as was the case with three of the male applicants, reminisced about holidays in Glenariff, Co Antrim, walks on the beach and swimming in the sea. Another of the female applicants said that, in the establishment in which she was placed, there were four swings for hundreds of girls and she never got to sit on any of them.

Medical Care

57 Seventeen of the 24 female applicants told the Forum that they had received medical care on one or more occasions during their placement in designated establishments. Four referred to attendance of their doctor; others said they were cared for in their establishment's infirmary and several spoke of "medical inspections". Three of them referred to having received dental treatment. The following table summarises the information they gave to the Forum.

Medical Care	Voluntary Female
Infirmary	3
Medical Inspection	3
Immunisation	1
GP	4
Designated Medical Person	1
Dentist	3
Hospital	-
Nurse	2

Applicants' Experiences of Discharge from the Care System

58 Female applicants spoke readily about their experiences of being discharged from care. Their memories of leaving and "moving on" were often sharply defined and recounted with considerable emotion. Eleven of the female applicants in this period left voluntary establishments to go to Australia under the child migrant scheme. They talked about the selection process, the mixed feelings of excitement and uncertainty about what they would see in the new country and the sense of sadness at leaving friends and, in some cases, siblings.

59 Four of the other female applicants said they were returned to their mothers when discharged from their establishments. In one case, the applicant and her siblings had been collected from a voluntary establishment by their mother. When she got home, she was sent out to work to earn her keep. In the family home, she had to sleep in a bed with six children, the children of the man with whom her mother was living. Another female applicant talked about her father coming to collect her and taking her, with an older sibling, to England where they were expected to work in a fruit and vegetable shop. She said she was very unhappy there as she did not know her father as a "Dad" and had no relationship with him.

60 Two other female applicants had been taken to work, in one case in a hospital and in the other in a private nursing home for older people, both establishments under the management of the same religious order that was responsible for the establishment in which they had been resident. Two female applicants had been discharged into foster care; in one case the applicant left a voluntary establishment and was placed with three of her siblings in the same foster home.

Post-Care Support

61 Most of the female applicants who had been discharged from care when they became fourteen years old, or during the year following their fourteenth birthday, made no reference to post-care support and assistance being provided. One of them told the Forum:

> "I got my own job, left the next day and no-one ever enquired if I was alright."

That said, from what some described in their accounts of where they went and what they did after leaving, it was apparent that some of the voluntary establishments made arrangements to place "leavers" in work and in hostels or "digs".

62 A female applicant commented on leaving care as follows:

> "I was taken without any preparation to work in a private home for the elderly that was also managed by the religious order that had been responsible for my care."

Five other female applicants spoke of being returned to family members on discharge.

Males: State Provision

63 The six male applicants who had been placed in state establishments in this period said little about the nature and adequacy of their care. Their primary concern was to talk about abusive experiences and those are included in Chapter 4 of this report. Those of them who commented on their care had generally favourable memories of their care with one applicant saying that his establishment "was a great place for children."

Diet, Clothing, Personal Care, Bedding and Heating

64 Four of the six male applicants commented on the food they had been given in their establishments, with two considering the food to be adequate in quantity and quality and two expressing dissatisfaction. The others made no comment. Three of the applicants recalled that their clothing and personal care were adequate. Three did not talk about those aspects of their care. Two of the applicants referred to their bedding as adequate - "comfortable" as one described it. None of the other four made any reference to bedding. Three of the six applicants told the Forum that the heating in their children's homes was adequate. The other three did not comment on heating.

Other aspects of Care: Work, Religious Practices, Play and Recreation, and Medical Attention

65 None of the male applicants who had been cared for in a state establishment commented on work as part of their daily routine, nor did they refer to religious practices or play and recreation. Two of the applicants recalled having medical attention, one in the form of a medical inspection and the other a hospital admission. They made no further comment about either experience.

Applicants' Experiences of Discharge from the Care System and Aftercare

66 None of the six male applicants who had been in a state establishment made reference to experiences of discharge or aftercare.

Females: State Provision

67 The one female applicant who had been in state care as a child indicated that, in general, she was well-cared for. She did not talk about specific aspects of her care.

Males: Juvenile Justice Provision

68 Neither of the two male applicants who had a placement in a juvenile justice establishment commented on the standard of their care.

Aftercare

69 One of the two male applicants who had been in a juvenile justice placement spoke appreciatively of the arrangements made by the establishment when he was discharged. Lodgings were organised and he received assistance with the weekly payments. In addition, a job was arranged for him. He said that:

> "(the establishment) had been helpful to him and got him started in employment."

All Establishments: Inspection, Positive Experiences and Education

70 The following section, arranged by establishment type, includes the recollections of applicants in Period 1 regarding inspections, the response of the establishments to inspection, applicants' positive experiences and education. As will be seen in subsequent paragraphs, there were some of these aspects of care experiences that only a few of the applicants could recall or chose to speak about.

Memory of Inspection and Visits from Outside Organisations and Agencies

Males: Voluntary Provision

71 Only six of the 41 male applicants remembered anything that might have been part of an inspection process. Some applicants referred to visitors arriving occasionally but said that the children were not informed in advance about their arrival or given details about their role, adding that sometimes they found out later who the visitors had been. More often than not, they said, they had been clergymen or important lay people.

Action in Voluntary Establishments in Response to Inspection

72 Only three of the 41 male applicants were able to recall action taken by the care staff in anticipation of, and during, inspections. One of them said that the children were warned in advance of the inspectors' visits and were told how to respond to any questions. The others remembered that

the premises were cleaned specially for the occasion. They pointed out that staff members were always present during the inspectors' visits and none of them had any memory of being spoken to by any of the visitors. One remembered that some children were hidden in another part of the premises during the inspection.

Females: Voluntary Provision

73 Five female applicants said they remembered people and circumstances that might have been part of an inspection, such as the premises being cleaned very thoroughly and the children being told to keep quiet and only to speak if spoken to by a visitor. They said no one told them anything about the visitors who appeared from time to time, adding that, occasionally, they found out afterwards who the visitors had been.

Action in Voluntary Establishments in Response to Inspection

74 Two female applicants were able to recall action taken by the care staff in anticipation of, and during, inspections. Both said that they were given better clothes to wear and also reported that the premises were cleaned specially for the visitors coming.

75 Generally the information given about their care by most of the applicants suggested that they were not aware of any formal or even informal monitoring and assessment of the provision or their general progress. A few remembered being prepared to read, recite and sing for visitors but they did not know why the visitors had come to their establishments.

Males and Females: State and Juvenile Justice Establishments

76 None of the six male applicants in state establishments could recall any activity in their children's homes that might have been part of a monitoring or inspection visit. Consequently they were unable to recall any action taken by care staff or others that might have been a response to inspection findings. The sole female applicant who was resident in a state establishment made no reference to monitoring or inspection. Neither of the men who had placements in juvenile justice establishments referred to any memories of inspection or monitoring.

Positive Experiences

Males: Voluntary Establishments

77 Nineteen of the 41 male applicants who had been in voluntary establishments told the Forum about memories of positive experiences and these fall into three broad categories:

- people who were kind to them or bonded well with them;
- special events and trips away; and
- making good friends.

The other 22 applicants made no mention of positive experiences. As noted elsewhere in this report, some of them had left their establishments to go to Australia and said they were too young to remember their care in Northern Ireland.

78 The positive memories recounted included the quotations below.

> "I had a real bond with one of the care staff; she taught me to play the violin and encouraged me to sing, telling me that I had a wonderful voice."
>
> "I was very attached to…(a member of the care staff). She was very good to me and on my Confirmation I was given her name. She died and I attended her funeral as an 11 year old. This still remains very painful for me."
>
> "I was very attached to…(a member of the care staff) who was a kind, motherly figure and showed me real love and affection."
>
> "(a member of the staff) was very kind and caring. She taught me Irish, and became my mentor helping me to get a scholarship to attend grammar school."
>
> "(a member of the staff) was a 'shining light' for me. I was very fond of her and she cared for me very well. I sang in her choir and she gave me violin lessons."

79 Several applicants spoke very fondly of the families who took them out from time to time. One male applicant spoke of the kindness of a family from North Belfast. He described a big family of very modest means who did not hesitate to take him out, along with his sister, as often as allowed, possibly three or four times a year. Another spoke of his sponsors for Holy Communion as being "great people" and their house being "like heaven." They took him to the pictures and gave him sweets before he "had to go back to hell."

80 The table that follows presents a summary of the types of positive experiences mentioned by nineteen applicants. Some mentioned more than one type, hence the total exceeds the number of applicants.

Positive Experiences	State Male
Helpful staff	6
Other helpful people, including friends	5
Fondly remembered events and outings	14
None	2
None mentioned	14
Total	41

Females: Voluntary Establishments

81 Ten of the 24 female applicants who had been placed in voluntary establishments made no mention of positive experiences and, of that number, five who had been sent to Australia as young children said that they had no memory of that period of their care. Two of the others asserted that they had no positive experiences at any stage. For the remaining twelve women, the most commonly mentioned good memories were of people, usually care staff, who had been kind to them and also of events, especially holidays and Christmas parties. Comments made included the quotations below:

> "...the local priest was kind and related well to us; he stood up for us and we felt safe around him; the care staff did not like him."
>
> "....(a member of the care staff) was nice."
>
> "...two other nuns were kind, brilliant. I would not class them (ie the staff) all the same."
>
> "I enjoyed trips to Donegal and being able to sleep in a hay barn."
>
> "I remember being taken to the pantomime and being given a bag of sweets as I went in."
>
> "Local people were kind and brought gifts to the home. I really liked the decorations at Christmas."

"Two lay staff were good to us; one would leave turnip skins for us to eat and the person taking out the slop food from the convent would let us raid the bucket."

"I enjoyed getting sweets from the Orangemen when they paraded past the home."

"I appreciated the care after neglect at home when my father was in hospital and circumstances in the family were poor."

"I made such good friends there."

82 The table that follows presents a summary of the positive experiences mentioned by female applicants who had been placed in voluntary establishments. Some mentioned more than one source of positive experience hence the total exceeds the number of applicants.

Positive Experiences	Voluntary Female
Helpful staff	3
Other helpful people, including friends	4
Fondly remembered events	7
None	3
None mentioned	10
Total	**27**

Males and Females: State Establishments

83 Four of the six male applicants who had been in state establishments did not refer to positive experiences. Of the other two, one said he was in a great place for children. The other talked about having a good ally in the workhouse. This was a man with a club foot; a rat-catcher who had a blackthorn stick and who protected him. He was also a scholarly man, who told him when it was safe to go out, in other words, when there were no predatory men in sight.

The one female applicant who had been in state care in this period commented that:

"the children's home was a good place; I had no concerns about the staff or the care provided."

Males: Juvenile Justice Establishments

84 The two male applicants who had been placed in juvenile justice establishments spoke briefly but positively about aspects of their care, one saying that the person in charge was kindly and looked out for him. The other reflected that it was better than the voluntary children's home he had been in previously and he enjoyed the trips to the seaside.

Education

85 The majority of the applicants from this period, from all types of establishment, had attended schools, some on the same site as their establishments and some in the neighbouring community. These schools catered for children in the five to fourteen age range, the normal age range in schools at that time. Re-organisation of education in the later 1940s changed provision to primary schools catering for five to eleven year olds and secondary schools catering for eleven to fifteen year olds. Some applicants who were in designated establishments in the latter years of Period 1 attended secondary school, having transferred from primary school at eleven years of age.

Males: Voluntary Provision

86 Most of the 41 male applicants who had been placed in voluntary establishments in Period 1 had received their schooling on-site, in accommodation set aside for teaching. Others from the voluntary sector had attended an adjacent school provided by the local parish or by the same religious orders that managed their establishments. In both cases, there were members of staff whom they knew both as teachers and as staff/adults in their establishments. That, for some applicants, was an unhappy arrangement as they saw "no hiding place" from some staff who were particularly threatening or harsh to them. Generally the applicants did not comment on the standards or quality of their education.

Females: Voluntary Provision

87 Fourteen of the 24 female applicants who had been placed in voluntary establishments made no comments on their experience in school. It bears repeating that many of them had left care in Northern Ireland before they were six years old and so had limited, if any, experience of formal education.

88 The ten who remembered something of their education had little to say that was positive. Generally their remarks were negative and included comments such as:

> "The teacher was very strict, she beat us regularly and I was always in trouble. Two lay people came in and they were very nice to us but we had very little education. One of the lay teachers asked me to help with her babies' class which I liked but I left school with no skills."

89 One female applicant criticised the standard of education saying that she had been doing well at school before admission to the establishment but once she was placed in the on-site school she made very little further progress. Another said that she did not attend school but was made to do cleaning instead and to this day is unable to read and write. A third woman said that she was sent to work in the on-site laundry and so, effectively, her education ended when she was thirteen. She said that, as a result, she was deprived of access to books and reading material. An applicant told the Forum that she was assigned to a "slow learners" class where she was neither taught nor learned anything. Another spoke of her experiences attending an off-site school where she said children from the children's home were teased and looked down on by others.

90 Fifteen of the female applicants said that they left school without formal qualifications. One woman completed her education at school in England. When she left Northern Ireland she could not tell the time or count and was barely able to write. She said that in her new school in England she excelled in religion.

Males: State Provision

91 The six male applicants who had been in state establishments attended schools in the local community. They made no comments on the adequacy of the education they received.

Females: State Provision

92 The one female applicant who was placed in a state establishment believes that she lost out as her education was inadequate. She said she was "good with her hands" but that was never recognised and built upon.

Males: Juvenile Justice Provision

93 Both male applicants received education on site during their placements in a juvenile justice establishment. They made no comments on the standards or quality of their education.

Conclusion

94 From the above, it is evident that for many of the applicants the time they spent in care was the most significant part of their childhood years. They knew no other home and, over time, the establishment in which they had been placed became their home. The experiences they were to have in care are now the substance of their childhood memories and, as a number of them explained, they can see both good and bad in what they recall. For them, as they expressed it so clearly, the challenge is living with what they should not have experienced, in what was meant to be a caring and protective environment.

Period 2: 1956 - 1975

Introduction

95 The Forum heard from 125 males and from 80 females who were in designated establishments in the period 1956 to 1975. The oldest male applicant who met with the Forum was born in 1941 and the youngest was born in 1968. The oldest female applicant who met with the Forum was born in 1944 and the youngest was born in 1972. Twenty-four of the applicants who were in designated establishments in this period were sent to Australia through the child migrant scheme. Only their experiences in care in Northern Ireland are included in this report.

Placements for Male Applicants in the Care System

96 The 125 males, who spoke to the Forum, were placed in 35 establishments in Northern Ireland. Of those 35 establishments, twelve were in the voluntary sector, sixteen were in the state sector and seven were categorised as juvenile justice provision. In total these applicants had 236 placements.

97 Some applicants were placed in more than one establishment and/or in more than one type of establishment during their time in care, for example they were initially in the voluntary sector and later in state or juvenile justice provision or they moved to another establishment within the same sector, for example, from one state establishment to another. The number of placements per applicant are set out below.

Number of male applicants	60	46	8	6	4	1
Number of placements	1	2	3	4	5	6

Fifteen of these applicants had had previous placements in the Republic of Ireland. The family of the applicant who had had six placements had led a nomadic lifestyle and he had been placed in children's residential establishments in England, Scotland, the Republic of Ireland and, finally, Northern Ireland.

Placements for Female Applicants in the Care System

98 Eighty females who spoke to the Forum were placed in 33 separate establishments in Northern Ireland during this period. Of those 33 establishments, 22 were in the voluntary sector, nine were in the state sector and two were categorised as juvenile justice provision. The female applicants had a total of 125 placements during their time in the care system.

99 Some applicants were placed in more than one establishment and/or in more than one category of establishment during their time in care, for example, they were initially in the voluntary care sector and later in state or juvenile justice provision or they moved between establishments within the same sector, for example, from one state establishment to another. The number and types of placements per applicant are set out below.

Number of female applicants	47	24	6	3
Number of placements	1	2	3	4

Five applicants had previous placements in the Republic of Ireland.

Applicants in Each Type of Provision

100 The following table shows the number of male and female applicants placed in each type of provision. Please note that some male and some female applicants transferred between the various sectors of care provision.

Gender	Voluntary	State	Juvenile Justice
Male	82	20	27
Female	74	10	7
Total	**156**	**30**	**34**

Circumstances of Admission into the Care System

101 Most applicants who met the Forum had little or no written information about the circumstances of their admission to care. Some applicants, because of their age when received or removed into care, were fully aware of the circumstances that led to their admission. Other applicants were reliant on information gleaned from parents, siblings or other relatives or, in a small number of cases, from staff at the establishment they had attended. The information presented below comes directly from the applicants and not from official records for, in the majority of cases, most applicants had not received copies of their records at the time they were seen by the Forum. The following paragraphs cover the age range and length of time applicants spent in the care system in Northern Ireland. It does not cover periods spent in care in the Republic of Ireland, England or Scotland or in Australia.

Age at Entry to the Care System

102 As shown by the table below, the majority of male applicants were taken into care aged between six and fourteen years old while the majority of female applicants were admitted to care when aged between two and ten years old.

Age at first placement	Male	Female	Total
1 year or under	22	12	34
2-5 years old	29	25	54
6-10 years old	36	22	58
11-14 years old	32	11	43
15-17 years old	6	10	16
Total	**125**	**80**	**205**

Duration of Placement in the Care System

103 The following table shows that the largest proportion, 41 per cent, of the 205 applicants who came to the Forum, spent between two and five years in the care system in Northern Ireland.

Years in care	Male	Female	Total
< 1 year	23	14	37
2-5 years	55	29	84
6-10 years	22	15	37
11-14 years	15	17	32
15-17 years	10	5	15
Total	**125**	**80**	**205**

Age at Discharge from the Care System

104 The majority of male applicants were discharged from the care system when they were in the fourteen to sixteen age range, while the age on discharge for females was more even widely distributed.

Age discharged	Male	Female	Total
<10	17	20	37
10-13	24	17	41
14-16	69	19	88
17+	15	24	39
Total	**125**	**80**	**205**

Reasons for Admission

105 From the information provided by applicants it was apparent that the main reasons for the admission of the male and female applicants to the care system were as follows:

Reason for Admission	Male	Female	Total
Parents unable to cope	30	28	58
Abandonment	27	15	42
Court Orders	30	12	42
Parents deceased	3	6	9
Other reasons	7	8	15
No information	26	10	36
Health	2	1	3
Total	**125**	**80**	**205**

The types of court orders mentioned by applicants or referred to in papers they brought with them to their meeting with the Forum included place of safety orders, committal orders – fit persons, orders for detention and training school orders.

106 The main reason given for admission to care for both males and females was that their parents were unable to cope. Within that group, the reasons that led to the admission of children to the care system were often a combination of circumstances. These included poverty, single parent households (mostly single mothers), overcrowding in very poor quality and inadequate accommodation, unemployment, domestic violence, alcohol abuse, mental and physical disabilities, desertion by one parent, imprisonment of one parent, death of one or both parents and homelessness either through inability to pay the rent or having to vacate the family home because of sectarianism. Children who were abandoned to the care system were, in the main, born outside marriage and remained in establishments for most of their childhood with few opportunities for fostering or adoption. In some instances it appears permission to place the children in another family was forbidden by their mothers. Many applicants had no knowledge of the circumstances of their fathers.

107 A small number of children who were abandoned were the children of mixed faith relationships and when problems emerged there was little or no support from extended family or from either community. One applicant said "we belonged nowhere."

108 Other reasons for admission to care included sexual or physical abuse by parent(s), serious neglect, absconding from unsafe care, own homelessness in teenage years, non-attendance at school, disability following accidents and unplanned pregnancy in teenage years.

Memories of Admission

Male Applicants

109 Thirty-seven male applicants had no memory of their admission into the care system; many of those had been very young at the time. The remaining 88 male applicants had some recall. Within the group of male applicants in this period a significant number were placed in a large residential establishment which had a remit to accommodate children of primary school age. Most of them transferred to another large establishment, the remit of which was to accommodate boys aged approximately eleven years of age and upwards.

110 A large number of the applicants who had been placed in care for a significant period of time talked of how they had witnessed older residents moving at age eleven or thereabouts to their new placement. Some

applicants commented that although they knew that they were going to move, there was no explanation about what the process entailed or where they were going. The boys moving to their next placement would often be part of a peer group and were transported by minibus by their new "carers" to their subsequent placement. One applicant remembered that he was terrified of leaving as he had been told by staff:

> "You thought it was bad here…wait until you get to…They are a lot worse. You had it easy here."

Some applicants said they had been looking forward to their next placement as they were hopeful that it would be an improvement on what they had experienced. Some recalled feeling excited as they would be able to have contact and reconnect with their sibling(s).

111 A concern noted by applicants was that their first placement, where many applicants had spent a large part of their childhood, was staffed predominantly by females and they had very limited contact with adult males. In their new placement, the staff group was very much male-dominated and this was described by some as unfamiliar and, initially, very unsettling.

Some comments from male applicants illustrate their recall about their care admission.

> "On admission we were given rosary beads and told if we lost them we would get a hiding. We were terrified of losing them."
>
> "I remember when I was four or five struggling in the arms of staff to get down to follow my mother who was leaving me."
>
> "I was taken from court, I was asked on admission if I was related to… (sibling) and told if I was anything like him I was in for a rough time."
>
> "I've no clear memory of the actual admission but I remember the first night and hearing my younger brother crying. We were all made to sleep with blankets over our heads."
>
> "At the age of eight I was told by…(named outside agency) that I was going on holiday to a big house and not to worry as I'd have a great time. As a result of this lie, every week I lived in expectation of being collected by my parents but it never happened and I was very disappointed. That's a life-long memory."
>
> "My mother deserted the family; she took my older sister with her. My father took the remaining children to…then father walked us up the long avenue to…My heart sank. I was received by (named staff). All smiles. It didn't last."

> "My father drank heavily. One day my brother came to our school and took me to my older sister's house. A woman who was there explained that because of my dad's drinking, my mother had left the family. Dad said 'you're all orphans now.' My older brother asked me if I wanted to stay with dad or go into a home. My older brother had opted for the home and so I followed him."

Female Applicants

112 Seventeen female applicants had no memory of their actual admission because of their age at that time. Sixty-three applicants had some memory, often one of feeling confused and uncertain. No applicant described any preparation for admission to care either by their family or by professionals involved. The following comments from applicants provide an insight into their experiences.

> "I was taken to court with my brothers and sisters…I was not aware that I could be sent away for not attending at school. I was very shocked. My parents were shocked…they were good parents but with a disability. We were well supported by the community in our original home. We had to move to an area where we had no local support system."

> "My mother came from the country…we were living in a town (named), some family members had a disability, we were isolated, the GP gave mum anti-depressants, she got hooked, the priest got the nuns to take us."

> "My parents were in a mixed marriage; large family, very overcrowded wee house. Mum went to the clergy for assistance, they sent a letter to the welfare, and took us to the home; the family stayed away."

113 An applicant, one of ten children, who was removed from her family when she was fourteen, told the Forum what happened to her:

> "My dad was a street angel and house devil; I was youngest of a large family. The priest advised my mother to send me away for training."

114 Another applicant who was absconding to avoid abuse in a care situation and who was subsequently placed in a training school said "nobody asked me why I was running."

115 An applicant placed in the care system at three years old told the Forum her experience of not being told her story while in care:

> "I was told my mother died in childbirth, I accepted that…I was not told I had a brother in the same place as me…we did not know of each other. Years later I met a cousin who told me my mother was still alive (single mother). Why was I not told the truth?"

116 Some of the applicants had a clear memory of their actual admission to the establishments and one applicant described it as follows:

> "I was taken there by car. I remember big gates, a big driveway up to it. They cut my hair off; they used a razor on my neck. I was put into a bath with Jeyes Fluid in the bath water. I was given toast, tea and put to bed. I had no explanation of what was happening."

117 Some applicants spoke of the preparation on the day of their admission although they did not know what they were being prepared for. One applicant, both of whose parents were deceased, remembered the day she was taken into the establishment:

> "They (family members) took me from school, took me to the hairdressers, and then to (named home)…my nightmare began as we went up the long drive and I realised this was different."

Another applicant, again who had lost both parents, told the Forum:

> "We all got new clothes and went up to my granny's street; all the neighbours were out… they were crying…everyone was crying. I was confused. We went up the road, then my little sister was taken at once to the nursery…I was crying and told to stop."

An applicant sent when she was fifteen to a mother and baby facility told her story:

> "I was fifteen, he was seventeen. We were from very different communities…I was pregnant…neither side was happy. My mother reported him for unlawful carnal knowledge…he got sent down. I was sent away for safety from both families."

An applicant who was three when she went into care explained what happened:

> "My mum had a bad stroke when my youngest brother was born…the family took all of my brothers and sisters but for me and my sister… when mum improved the others went home…she tried to get us back… staff kept saying we were doing well and it was best to leave us."

118 Another applicant who was separated from her two brothers in the car that drove them from the courtroom explained "I lost everything that day." An applicant who was removed from a very neglectful home was pleased when she got to the establishment where she was to live for the next twelve years: "It was lovely and clean, my bed was clean and I was fed."

Referral Source/Agencies

119 Sixty of the 125 males and 31 of the 80 female applicants did not know whether or not they had been referred to the establishment where they were placed. The following table sets out what applicants understood in relation to referral agencies.

Referral Source/Agency	Male	Female
Not known	60	31
Welfare authorities	18	17
Local clergy	18	12
Courts	22	12
Police	3	3
NSPCC	4	3
Vincent de Paul Society	-	2
Total	**125**	**80**

Aspects of Care in the Residential Establishments

120 The experiences of the 125 males and of the 80 females are set out in this section of the report under voluntary sector provision, state sector provision and juvenile justice provision categories. Applicants' accounts are described by gender within the three individual sectors. Applicants' accounts of the five general care conditions of food, clothing, heat, bedding and personal care are included. Where any of these experiences are described as abusive or neglectful, this information is included in the Abuse/Neglect section of chapter 4 of this report.

Voluntary Provision

121 The first part of this section covers the reports from 82 male applicants who had a total of 120 placements in twelve individual voluntary establishments.

The second part of this section covers the experiences of 74 females who had a total of 90 placements in 20 voluntary establishments.

Males: Voluntary Provision

122 Eighty-two male applicants spoke to the Forum regarding their experiences of day-to-day living within the establishments in which they were placed. Their opinions of their care conditions are set out in the table below.

Aspects of Care	Good	Adequate	Poor	Very bad	No memory/ not disclosed	Total placements
Diet	3	37	37	7	36	120
Clothing	3	41	18	2	56	120
Heat	5	36	8	3	68	120
Bedding	5	39	7	1	68	120
Personal care	4	32	31	8	45	120

Diet

123 Some of the male applicants who described their diet as very bad referred to the quantity rather than the quality of the food. Applicants who remembered the food as very bad, spoke of the food being inedible and of feeling hungry on a regular basis. In other circumstances, applicants explained that the food, at best, was not to their liking and described being given lumpy porridge, stews and over-cooked vegetables.

124 Applicants made the following comments with regard to their diet:

"The food was basic….we had no choice."

"I had to eat porridge and fatty bully beef."

"The food was basic: cabbage, macaroni, hard baps with margarine and yesterday's doughnuts."

"I was starving all the while."

"I was hungry and ate raw potatoes out of the ground and used to try to steal food from the pantry."

"Eggs went to the staff and not us boys."

Several applicants recounted that a significant issue with food was that the older boys were able to take more than their fair share, leaving the younger boys with less to eat.

Personal Care

125 Many applicants who described personal care and hygiene practices as very poor were placed in two large establishments in the 1950s and early 1960s when showers were not available and where shared baths with liberal use of Jeyes Fluid were customary. Applicants described a lack of privacy, sharing towels or sheets that were often very wet by the time they could be used, as they were the last children in the queue. One applicant described rough handling by a local barber who attended at one establishment; he said "we were lined up like sheep."

Other Care Provision

126 Applicants did not enter into great detail about their clothing, heating or the supply of bedding in their placements. Some applicants stated that the boys wore the clothes they were given. They described hand-me-down clothing and said there were no options for them to choose from. One applicant reported that the shoes he was given were ill-fitting and had left his feet deformed as a result. Many aspects of the care experiences of the males who spoke to the Forum appear to have changed for the better from the mid-1960s onwards.

Work

127 Forty-three of the 82 male applicants did not comment or were too young to remember any experiences of having to work when in their placements in the voluntary establishments. The remaining 39 applicants commented as follows: ten applicants described being responsible for chores such as helping to prepare food, laying the table for meals and keeping their bedroom tidy; two applicants commented that they enjoyed helping out, with one receiving extra pocket money for successfully completing his chores. None of these ten applicants viewed their chores as onerous.

128 Twenty-nine applicants felt the work they were required to do was excessive and a few applicants viewed it as punitive. One applicant said that he was made to work on the farm every day after school, every weekend and holiday period. Several applicants recounted that their weekly duties consisted of having to wash, wax and polish long wooden corridors every weekend. Some of these applicants recalled having to wear rags on their feet to make the floor shine. One of these applicants commented that

there was an electric buffer in the store room but it was not allowed to be used. Another applicant commented:

> "We were made to polish shoes and if not done properly, we got thumped by the older boys."

129 Several applicants spoke of having to work on the adjacent farm with one applicant commenting that he was kept from school in order to complete his chores. The duties applicants spoke about involved tending to the animals, picking potatoes and stacking hay. Several applicants gave accounts of being hired out to neighbouring farmers to dig potatoes and receiving no payment for their work: "It was slave labour, you got nothing for it." Some of these applicants said they were sent to farms across the country and it was dark when they left their establishment and dark when they returned.

Religious Practice

130 Some applicants did not refer to this aspect of life in their establishments. Other applicants said they had always had their religious beliefs and that this has remained very important for them. One applicant recounted that "the staff were gentle people who often prayed."

131 A number of applicants referred to having to attend their place of worship daily, taking Communion and attending Confession. This was not always described negatively or to their detriment. Some applicants said they had lost their faith, but in later life, had returned to it.

132 Some of the applicants who described religious practices in their placements as excessive and taking precedence over other care factors such as their education and social development recounted the following:

> "…religion - morning, noon and night."
>
> "It was constant – you were up every morning at 6.30 – 7.00 to serve Mass" (and he particularly remembered Easter as he was serving at High Mass and Low Mass, as well as saying the Rosary and Benediction).
>
> "Where was God when this was happening to us?"
>
> "Religion was thumped into you…it turned me off religion."
>
> "I didn't like it; I hate it; detest it. I don't care about religion; I resent religion. You were either working or praying."
>
> "I remember kneeling by the bed and being freezing cold and having to pray."

"It was perpetual – non-stop. Praying, Mass, Angelus, choir."

"Staff were obsessed with religious practices and routines for children."

"The home was more concerned with religion than education."

133 One applicant said that he was stopped from going to stay with his grandmother with whom he had a strong attachment, as she was not taking him to church. The staff believed his grandmother was bringing him to another church. This still resonates with the applicant as he was very tearful when relating this to the Forum. Another applicant recounted being made to kneel for long periods of time in church because of what he described as "minor infringements of the rules."

Play and Recreation

134 Fifty-one male applicants made no mention of, or complaint about, recreational facilities and activities. The remaining 31 referred to a range of activities that were available to them. These included watching television and sporting facilities such as a swimming pool, table tennis room, hurling pitches and basketball courts. Applicants referred to a playroom and outdoor swings in the grounds of one of the establishments. A few applicants recalled fond memories of being taken to Christmas parties provided by local businesses and being given presents.

135 Two applicants described going to the nearby town disco at the weekend, if they were not on home leave. Equally, a number of applicants were regularly taken to seaside resorts for a few weeks over the summer period and spoke of spending most of their time on the beach. An applicant remembered visitors being allowed to come at Christmas, once or twice over the years. They brought gifts for the boys, such as roller skates, which they were allowed to keep. One applicant when speaking of the recreational facilities referred to having nothing but a few old swings adding:

"one day was the same as the next....I was doing things at eleven that I did when I was five."

Medical Care

136 A large number of males did not comment on medical interventions, including dental examinations and treatments.

137 Fifteen male applicants commented on the lack of treatment from medical professionals. This included applicants who spoke of being beaten by a staff member, two of whom were hospitalised for these alleged attacks.

One recounted that, as a result of his attack, he had a head injury but was not brought for a medical examination or treatment. One applicant gave an account of an assault when he was stabbed by another resident but he was not taken to hospital.

138 Another applicant recalled a doctor visiting the establishment and the children getting their inoculations. This applicant also referred to being taken regularly to the dentist for treatment. Two applicants described having serious ailments as children, requiring them to be hospitalised. Three applicants recounted being on bed-rest in their establishment and being cared for by staff members. An applicant was hospitalised as a result of a severe beating by a member of staff who hit him on the head with a wooden towel rail (similar to a large rolling pin). This applicant was an in-patient in hospital for a significant time as he alleges his skull was fractured.

139 The following quotations and comments are typical of the information provided to the Forum:

> "I was sick for three weeks and I've no recollection of being seen by a medic but only of being left in my bed in the dormitory."
>
> "I was taken to the local hospital following a fall from benches."
>
> "A doctor would come up and treat or examine the boys."
>
> "When I was three or four years old, I injured my leg when playing in the yard. I received stitches. Another incident occurred when I was around twelve or thirteen years old and making rugs. My eye was knocked out of its socket and I went to hospital for two weeks. I didn't want to return to the home as I was pampered in the hospital."
>
> "The GP would visit but rarely. I had blisters (an allergic reaction to tomatoes) and was kept off school for two weeks and treated well by kitchen staff who gave me soup."
>
> "Older boys took the younger children to the dentist."

An applicant recounted being very under weight as a child and always fainting but has no memory of being taken to see a doctor.

Applicants' Experiences of Discharge from the Care System

140 Twenty-eight of the 82 male applicants did not discuss their discharge arrangements or their experiences of leaving their residential placements. The remaining applicants did not always talk in detail but the following information was recounted to the Forum.

"I went home to a father who abused us."

"I was sent back home to my father who was an alcoholic and violent… Nothing had changed."

"I was sent home to a very violent household and nobody checked up on us."

141 Some applicants who were discharged from care at fifteen or sixteen years of age spoke of the frightening and dangerous experiences they were exposed to once they had left residential care.

"When I left school I got work in a laundry but I still lived at the home. One day when I returned, I was met at the side door and told by a member of staff 'you are leaving today'. I didn't get a chance to say goodbye to anyone and I was placed in a boarding house. On my first night there, I was raped anally by a drunken man."

"I was put with my older brother in a boarding house and a man tried to sexually assault me."

"I went to work in…looking after horses and slept in a barn. I ran away to live with an uncle in the city…approved by the welfare, but that didn't work out."

"I left school as a fifteen year old on the Friday and a few days later, I was taken to … to work with old people."

"I was put in digs with other ex-residents. I received no support."

142 Some applicants gave accounts of the loneliness and isolation they felt as they realised they were alone for the first time in their lives and they had no support systems in place. They felt abandoned for a second time. One applicant described what he referred to as his release:

"It was the loneliest day of my life. I had a bag, the same as the Chancellor's, with two sets of underwear, socks and a suit in it. I had no parents, no family."

143 Some applicants said they felt different from their peers who had grown up in family care. They explained this as not just dealing with the stigma and shame of growing up in the care system but more a feeling of being different. As said by one applicant,

"I felt as though I was on the outside" and described other teenagers as seeing him as "simple."

Another applicant reflected, "I didn't know a single pop star or a film star" and said "I was unable to relate to others who hadn't been in care."

144 Some of the applicants were discharged to, or managed to find, lodgings. There was a general consensus that the quality of the accommodation provided was poor, overcrowded and two of the witnesses described further serious sexual abuse by older men in their accommodation. Between 1970 and 1976, those discharged described their terror at being placed in areas where tensions in the community were very high. Some of the applicants, who had been in long-stay care and placed in a rural setting, felt they were not fully prepared to deal with the Troubles and felt very vulnerable when they left care. An applicant, who had been in residential care and discharged in the 1970s, commented:

"I knew nothing of the Troubles....I was thrown into the midst of chaos."

145 A few applicants said they became involved in paramilitary organisations as a way of getting some protection or even a sense of belonging. Following his discharge, one applicant was very seriously assaulted when he wandered into an area where he was stopped by a group of males and questioned about his religion. His pockets were searched and his rosary beads were found. This applicant had to be hospitalised for some time as the result of the severe beating he received. Other applicants made the following comments in regard to their discharge:

"There was rioting at the end of the road. I didn't know what to expect."

"There were bombs going off. I was frightened."

146 One applicant, discharged at fifteen years of age and who remained under the care of Social Services until he was eighteen years of age, said his social worker found lodgings and work for him. He reflected that leaving his care establishment was a very sad time for him as he was entering into a world he didn't really know nor understand. He also missed the residents who were like family to him.

Post-Care Support

147 In total, six male applicants said they were offered appropriate post-care support, and described this as getting assistance with welfare benefits and housing. Applicants who spoke of their discharge from care felt there was little help to assist them to reintegrate back into family life or develop the life skills they needed to manage in the community. Applicants told the Forum the following about the conclusion of their time in care.

"I was put in digs with other ex residents and received no support."

"I had no preparation for leaving – I was just told I was going when I arrived back from school. I was sent to a hostel in Dublin."

"I had no idea where I was going, no aftercare, and no preparation for leaving – only digs, where subsequently I was sexually abused."

"I had no preparation for discharge apart from being given work boots and, on the day of leaving, being given a girl's coat, playing cards and religious icons."

"I had no social worker and at sixteen I was on the streets. I didn't know about sex or women…I feel angry still."

"I was never given a childhood."

"I was given a suitcase and a religious picture with 'Wishing you all the best' on the reverse."

"At fifteen years of age, I was told it was time to leave. I was called into head staff member's office and told 'You are going out into the big bad world'. I left with what I had on me and a small suitcase with a pair of short trousers, a tank top, a vest and underpants."

"I was placed with a family and given a job on a building site pulling nails out of timber. I had no other assistance."

Females: Voluntary Provision

148 Seventy-four female applicants spoke to the Forum about how they experienced day-to-day living in the establishment in which they were placed. Their opinions about aspects of care are set out in the table below.

Aspects of Care	Good	Adequate	Poor	Very bad	No memory/ not disclosed	Total Placements
Diet	-	14	30	13	33	90
Clothing	4	29	22	2	33	90
Heat	2	35	12	2	39	90
Bedding	3	34	13	4	36	90
Personal care	11	9	28	17	25	90

The table shows that, across the five aspects of care, two were more often the subject of negative comments than others. These were diet and personal care and hygiene.

Diet

149 The quantity and/or quality of the food provided in the voluntary sector was described as adequate or good in relation to 31 placements. In 33 placements, the food was described as being poor or very bad. The reports relating to poor food were not time specific but were distributed across the entire time period (1956-1975). The reports of the food being described as good came largely from applicants who had been placed in smaller establishments where choice and preferences were more easily provided for.

150 The following comments typify the female applicants' reported experiences:

> "Poor quality food, not enough to eat, I was always hungry. I was forced to eat semolina and bread pudding even though it made me sick."
>
> "...I ate food that was down for the dog as I was so hungry...I still feel so guilty about this."
>
> "The food was very bad, bread and dripping, grisly fat stew, it was inedible, I was always hungry."
>
> "The food included cold lumpy porridge and greasy fries. I was always hungry."
>
> "There was donated food but this was not given to the children."
>
> "I picked chewing gum off the ground as I was in constant hunger."
>
> "If you refused to eat the food (inedible fat, gristle) they would take it away but then bring it back until you ate it. I wasn't starved but I was hungry and would steal food if the opportunity arose."

Clothing

151 The provision of suitable clothing was described as adequate or good by applicants who had been in 33 of the 90 placements, while in 24 placements it was reported that the clothing provision was inadequate. The complaints concerning clothing focused on the sharing and the uniformity of the clothing provided. These applicants spoke of what they regarded as unreasonable demands that clothing had to be kept pristine for long periods of time, and that they had to have their sleeves rolled up.

152 A number of applicants attended school near the establishment and most of them said that they "stood out" as their uniform was of a sub-standard quality when compared to that worn by the other girls in school. In some placements the shoes provided were second-hand and ill-fitting. Several

applicants recalled that getting a pair of shoes of the right size was a lottery. Towards the latter part of this period there were more positive descriptions of applicants being taken shopping for new clothes, being allowed to have choices in the selection of their clothes and the introduction of individual clothing allowances.

Personal Care

153 The second aspect of care about which applicants expressed negativity was personal care including: bathing arrangements, practices regarding menstruation and general personal grooming. In 45 of the 90 placements this aspect was described as poor or very bad, while just 20 of the 90 described this as satisfactory.

154 The following comments illustrate the experiences recounted by the applicants:

> "There were shared baths and shared drying towels. The only item for self care was a wash cloth and very small towel."
>
> "There was no privacy at all. Jeyes Fluid was mixed into the bath water and so much was used it left brown marks on your skin. We had to strip to the waist to wash regardless of age."
>
> (Menstruation) "We had to go and ask for sanitary towels. the staff might say 'I gave you one this morning'; no extra baths were allowed, legs became chaffed, it was embarrassing."
>
> "At bath time we were like animals in a shed lined up ready, one child in the bath, one sitting on the edge of the bath washing her feet, others lined up awaiting their turn in the same water."
>
> "There was no sex education or training in personal hygiene…I left ignorant of the developments I would experience in puberty…I was not taught about menstruation."
>
> "I wet the bed and was not allowed to wash myself before school."
>
> "I was made to sleep in a wet bed with my younger sister – it was a cold wet bed. I had to bath after all other younger girls were washed – the water was dirty and slimy."

Other Care Provision

155 The other areas of care provision commented on by a minority of applicants were heating and bedding. Where comments were made, they were generally positive.

Work

156 Thirty-five of the 74 female applicants who were placed in voluntary establishments in Period 2 advised the Forum that they did not have to perform any onerous work tasks while in their placements. Of that number, some applicants were too young to remember as they were in nurseries and some were happy that the chores they had were not taxing. Other applicants had no recall of undertaking work duties or did not refer to any during their meetings with the Forum.

157 Thirty-nine applicants in placements in the voluntary establishments spoke of being allocated work on a constant basis from age five upwards. Work included a range of tasks from bed making, scrubbing, waxing and polishing floors, being responsible for younger children including babies who required feeding during the night, spring-cleaning classrooms, scrubbing toilets and bathrooms and caring for elderly residents in adjacent accommodation. Working in industrial-style laundries was reported as a constant feature by some applicants and most of them had been given this work from twelve years upwards. Some applicants recalled working at big tubs from age eight and having to stand on steps in order to reach the large sinks.

158 The majority of the establishments were described as places where the children did the everyday work to keep the accommodation clean. The work was described as onerous, often beyond the age capability of the child. It was noted by applicants that a very high standard of work was expected. The staff or older residents supervised their work and if they were unhappy with the outcome, then it had to be redone. Some applicants spoke of being kept off school if they had not finished their chores in the morning; some remembered being kept away from recreational facilities and some had to undertake extra work late into the evening as punishment. The following comments and descriptions from applicants are indicative of the experiences shared with the Forum:

> "Every day I had to get up at 6.00am and had twenty-four babies' nappies to change (my younger sisters helped). We dressed the babies, changed sheets if needed, washed nappies and put them to soak in Napisan. We had Mass, breakfast and school. If there was no school we brushed the floor, washed the tables and chairs, dusted and looked after babies… I was always working."
>
> "We were made to lay out the dead. One time when I was about nine years old, I had to go with my friend (another resident) and lay out an

old lady with whom I had had a good relationship. This lady was an amputee and both of us had to bath and lay her out."

"Regularly I had to bring a trolley down to the 'dead house' and tend to the corpse – hair, powder puff etc."

"I had to paint my bed every summer – it had a cream metal frame – and I had work in the laundry and in the old people's home."

"I had to clean six toilets and floors each morning before school…my work was inspected and if I failed then I had to do it again…school was not the main thing."

"I was made to polish floors and work in the morning before and after school – on cold tile floors on bare knees polishing with no respite."

"…life was filled with house-work…cleaning and scrubbing in the children's home and in the classrooms and…replacing light bulbs. There was little time to be a child."

"I was made to work in the laundry and the washroom but, when I couldn't manage the ironing (I burned the clothes!), I was then sent to the stitching rooms."

Religious Practice

159 Thirty-five of the 74 female applicants made no reference to religious practices in their placements. Eighteen of the 39 applicants who did comment on religious practices spoke of attending Mass on a daily basis, of regular morning and evening prayers and of attending other services. Religious observance was described as part of everyday life. Comments about religion were more common in the accounts of those who had placements during the 1950s and 1960s and were less prevalent in the 1970s, although attendance at Sunday services and morning and evening prayers continued to be mentioned. For some applicants their religious observance was accepted as good or positive, while for others it was regarded as something that was overemphasised and not welcomed.

160 Some comments from applicants illustrate what the Forum was told about religious practices.

"We had to say the Rosary nightly and got sent to Benediction every other night…in Confession I had to say that I had done something wrong and confess."

"I had to go to the early Mass some weeks…part of some rota. Then off to retreats for three days each year…no talking was allowed. We always were made to kneel to say the Rosary each and every night."

> "It was pray, pray, pray…before breakfast, Rosary after school…pray for every Tom, Dick and Harry all the time …when President Kennedy died…they hauled us all out of bed to pray for him…If a nun died…she was laid out in an open coffin… we had to go in and pray for them."
>
> "We were always praying…the staff would get children up in the morning by clapping and immediately all would jump out of bed and on their knees to pray. Prayers last thing at night and first thing in the morning. The nun would still be very alert even when she was in her cell…we all said our prayers."
>
> "Services on Sunday morning, Sunday school and services in the evening …I was smacked across the face in God's name…"God would not want you to do that' I was told."

An applicant who had been in a home in the 1970s, said she "enjoyed the smell of incense and loved the Benediction."

Play and Recreation

161 Forty-five of the 74 applicants did not discuss or refer to any recreational facilities. From the comments of 29 female applicants it became evident that many establishments had outside play areas and some equipment. This equipment was described by some as being rusty and inadequate, particularly in the larger establishments given the numbers of children accommodated there. The following are typical of comments made about outdoor play facilities:

> "The play ground/yard outside had a climbing frame – a rusty climbing bar."
>
> "Other equipment – such as a slide – was presented by a donor but this was removed by staff."
>
> "There was some play equipment but girls were not allowed to climb."
>
> "The noise level was awful…no peace…I tried to find a quiet place to read."

Many experienced the play yard as a place of fear because of the noise or the danger of being knocked over as girls charged around. For others, it provided an opportunity to be outside and a place of enjoyment, even if only for a short period.

162 Recreation also included access to some television shows, watching films on Sunday evenings, and having record players. During the late 1960s and early 1970s, in some establishments, the older girls had a separate sitting

room which made life more comfortable for them. In one establishment, bikes were provided and the older girls were allowed to cycle into the local town on Sundays.

Comments made by applicants included:

"TV was switched on for the News. At Christmas time we were allowed to watch."

"We had occasional access to television - any kissing on TV meant the telly was always turned over."

"… me and another girl were watching 'Top of the Pops' and mimicking Pans People dancing – I was told I was immoral. I was made to stand outside the staff room for hours."

"Each group had a sitting room. We could watch limited TV, there was more freedom once I turned fifteen. There was a big room with music but we were only allowed in there occasionally…any noise and you would be sent out."

163 Many applicants spoke fondly of going out to parties organised for them by local businesses and the joy of getting a present and eating food not normally available to them. They spoke of the excitement in the build-up to such outings and the disappointment and hurt if permission to attend was withdrawn for some misdemeanour. Most, but not all, applicants recalled that the presents they were given were removed on return to the establishment.

164 Some applicants referred to going on walks on a Sunday and this was welcomed as providing an opportunity to get out and for some it provided the only opportunity to see their sisters. For others it was a painful experience in that they felt humiliated at having to walk in a crocodile line.

165 Other recreational activities commented on included dancing classes, playing in bands and attending the Feis or other competitions. In establishments where music and singing were encouraged, those who were not musically talented were allocated extra chores instead.

166 A number of applicants described being taken on holidays for a week to a local seaside area. These holidays were generally spoken of as a time when the girls had more freedom and time to enjoy themselves. However, for some of the older girls the routines of cleaning, washing up and caring for younger children filled their days when they were on holiday.

167 Seven applicants spoke of experiencing little or no recreational activities. Instead, they were engaged in work chores, kept indoors or away from play. An applicant who was placed with a younger sibling spoke of the emphasis on completing chores after school to the detriment of playtime:

> "my chores took all my time after school…I constantly looked out for my sister…little room left for any recreation…I was frightened all my time there."

Medical Care

168 Fifty-seven applicants did not remember, or did not refer to, any medical care in the establishment in which they were placed. Some of the seventeen applicants who described medical care referred to a variety of interventions including immunisations, general practitioner visits and/or clinic attendance, hospital attendance or admission, being placed in a sick bay on site and dental treatment. Others did not remember any medical interventions when they believed their illness or injury would have warranted attention. The following comments illustrate what applicants told the Forum:

> "I was diagnosed as coeliac and given the wrong types of food. As a result, I was frequently sick. I was taken to…Hospital following a particularly severe beating from the woman in charge of the home."

> "The doctor called, he saw the new children, he checked them. I think it was fortnightly. I saw him once, I had bad flu. If you were ill, other children were responsible for bringing up food or medicine to you. A girl with jaundice was isolated and it was my job to bring her all her food and medicine. A kind member of staff brought me gruel with sugar when I had flu."

> "I recall being asked by the dentist about teeth hygiene and I told him that there was no toothpaste in the home. He contacted the home and I was made to stand on a chair for hours and was hit with the side of a ruler on my knuckles by a member of staff."

> "I never saw a doctor or nurse – I had scabs on my head which another child was made to brush out; it was very painful, I passed out. There was no medical help."

> "My knee split open and would have required stitches, but I was not seen by a medic."

> "Injuries caused by staff were hidden. If you were bruised you had to wear tights and were given a note for school so no PE. At hospital you were not allowed to speak, staff did all the talking."

"I suffered from severe acne when I was a teenager and got no medical attention for it."

"They looked after cuts and grazes, and used iodine and Jeyes Fluid. I had ringworm and was taken out to a clinic."

Applicants' Experiences of Discharge from the Care System

169 The 74 female applicants who were in 90 placements in the voluntary sector spoke to the Forum about their discharge from those placements as follows.

- Thirty-four applicants were discharged home at various ages.
- Twenty applicants left the establishment to commence working.
- Seven applicants were placed in adoptive or in long-term foster care families.
- Four applicants were sent to juvenile justice establishments because they were absconding.
- Four applicants were transferred to establishments in the state sector.
- Three applicants were sent to laundries run by religious orders where they remained for some years. As reported to the Forum, applicants did not have a choice in this matter.
- Two applicants went to other placements: one to further education, where she lived-in and one joined the armed services.

Post-Care Support

170 Only seven applicants told the Forum that they had been offered good support after leaving the care system. Most applicants described little or no preparation for leaving their placements and many applicants who were sent home reported that they were by then estranged from their families and communities and went back to strangers. Applicants reported being told they were leaving only on the day of their departure or at best the day before. Some comments from applicants illustrate how this aspect of care was experienced.

"I was placed on an aeroplane unaccompanied to…where I was met by mother who was like a stranger… there was no support from anybody…I was just told I was going home tomorrow." (The applicant was twelve at the time.)

"I ran away, was brought back, couldn't settle, next thing I was put in a van and landed in…most of the people there were very old…I never got out…it closed when I was about 25…lucky me."

"I was given a job in the convent... cleaning, serving food to visitors... answering the door etc. I got £4 per month, and food and board. Eventually one of the other girls got me a job in a factory. I left and started living."

"...I was sent back to them (parents) why? I had been taken away because he (father) was abusing us...he just continued." (This applicant returned to care at a later point.)

171 A small number of applicants who persistently ran away from the establishment in which they were placed were sent to juvenile justice establishments. One applicant who ran away at thirteen was convicted of an offence. She told the Forum that the staff from her first placement did not prepare her for this possibility and she did not understand what had happened in court: "No one explained to me."

172 Very few applicants talked about being trained in basic life skills such as cooking, budgeting and shopping. For many of the 20 applicants discharged into work, often living in hostels initially, life was for some years very difficult as they struggled to master the basic necessary skills for survival. This was particularly true for those applicants who had been raised largely in institutional settings in the care system.

173 Many, but not all, applicants described that an initial job had been found for them. They had no work or life skills so the jobs were at a very basic level, for some no work was secured. Many left Northern Ireland shortly after their discharge from care to seek work in England. Many of those had no family contacts to fall back on but some were fortunate to be living with, or in contact with, people they knew from their placements who were helpful and supportive.

Return Home

174 Thirty-four applicants were discharged to the family home. For some this was a good and positive experience and they rebuilt their lives as a family unit. Comments included:

"Soon as they got a house...we were home. I never told them what had happened...how could I?"

"...after a few months...the court sent us home. Welfare would still visit; we saw them for years...eventually the visits stopped."

175 For many applicants going home meant returning to families from whom they had become estranged; their parents had new partners who were strangers to them. They had new siblings or half-siblings and they were

expected to settle down and attend new schools or go to work in new communities and, in a few cases, in entirely new countries. For some, the underlying family difficulties of alcohol misuse, physical or sexual abuse or domestic violence had not changed and many of the applicants in these situations left home as quickly as possible. Some applicants said that they felt their families had only taken them out to make them 'unpaid skivvies again' while others spoke of parents sending them out to work as soon as possible and taking all their wages.

Adoptive or Long-Term Foster Care

176 Seven applicants were discharged to long-term families; three were adopted while four remained in long-term foster care. Two of them went to foster or holiday families who had befriended them while they were in the establishment and this was described as a very happy outcome. One applicant, whose mother was a single parent, described being adopted at age five. Her mother signed the legal papers. When the applicant traced her mother in later life she discovered that her mother had not been fully informed about the meaning of adoption and that all parental rights had been removed from her. The adoptive placement was a very positive one and the applicant became tearful when speaking about her adoptive parents as they are now both deceased. These types of placements out of long-term residential establishments were made mostly in the late 1960s and in the 1970s.

Reporting Abuse

177 Most applicants left the care system and did not speak further about their childhood or any abuse that occurred until some ten years or more had passed. The 42 applicants who described some or all of the aspects of their experiences in the establishments spoke to their partners or counsellors. More recently, applicants have spoken to the police. A few applicants have told their own children as they grew up or asked questions about their background and family of origin. Most applicants spoke of wanting to avoid the stigma of being raised in care, or placing the burden of their experiences on the shoulders of their children. The fear for everyone was that no one would believe them and some expressed their relief at finally having the opportunity of speaking freely of their past.

State Sector Provision

178 Twenty male applicants had a total of 30 placements in 16 individual state sector establishments. Ten female applicants had a total of

eleven placements in nine individual state sector establishments. These placements included residential child-care establishments, hostels, residential medical settings for children and young people and an assessment and reception centre. The establishments in the state sector were smaller residential units admitting both male and female children of a similar age range, for example primary or secondary school aged children. Most applicants spent a maximum of one year in each placement and for some applicants their placements lasted for a few months only.

179 This section of the report is divided into two parts. The first part covers the experiences of male applicants in state sector placements while the second covers the experiences of female applicants.

Males: State Provision

180 The twenty male applicants who spoke with the Forum had a total of 30 placements in sixteen individual state sector establishments.

- Fourteen of the establishments were smaller, community, residential units admitting both male and female children of a similar age range.
- One establishment admitted males only.
- One establishment was a medical setting undertaking assessment and treatment of children and young people.

181 The following indicates the number of placements of applicants in the state sector.

- Thirteen male applicants had one state sector placement only.
- Four male applicants had two state sector placements.
- Two male applicants had three state sector placements.
- One male applicant had four state sector placements.

Other Care Placements

182 Following their placements in state establishments, three applicants were transferred to three different voluntary establishments. Additionally, two male applicants were admitted to two different juvenile justice establishments.

Care Conditions

183 Several male applicants either had no memory of, or chose not to comment on, the general conditions in their placement, such as food, clothing, heating, bedding and personal care provided. The remaining applicants described the care amenities in their placement(s) as either

adequate or good. None of the male applicants expressed any complaints about the general care conditions in their state establishments.

184 One applicant who had had two placements in the state sector, differentiated between both establishments, describing the care in one as "not too bad" and the other as "pure torture."

185 One applicant recounted positive memories of his placement in a state establishment. He described his placement as:

> "a supportive family environment. I have no complaints; I have the height of praise for the ethos and practice."

186 One establishment in the state sector had education on site. Children resident in the remaining state establishments, if of school age, attended school within the community.

187 The following comments give a sense of applicants' views of their state care provision:

> "Staff were not all bad; there were some nice people but also bad apples."
>
> "I was very unsettled and resented the strict regime. I was missing contact with my family, hiding and running away frequently."
>
> "I absolutely hated it from day one. I was scared there all the time."
>
> An applicant described a gang of about five older Belfast boys who were in the establishment:
>
> "There were three other boys in the home as well as me who were not street-wise. The older boys were engaged in street disturbances and I saw staff give them money regularly. My social worker Miss…was a young woman and she never entered the home…after day one. She saw me in her car round the corner from the home."

188 An applicant described his placement as "positive" and referred to three members of staff as "lovely to me." Another commented that his placement "worked very well". He was very enthusiastic about and appreciative of his care. Other positive views expressed included:

> "The housemother was warm and all staff very approachable. I was taken out each Saturday by…to her parent's home for tea."
>
> "I had lots of food, clothes were clean and a clean bed. I was never hit, I could talk to people."
>
> "I was happy in every way in…"
>
> "I loved it – I felt settled and secure in my placement."

"It was a happy place, it gave you a warm feeling."

"Overall it was very positive and I could see my sisters."

189 Those applicants who commented on the recreational facilities available to them described toys and games, involvement in extra-curricular activities and, in certain establishments, grounds in which they could play. One applicant reported the following:

"There was a common room for games, and residents could also play outside…it was an open establishment…you were not locked in."

One applicant who was approximately nine years of age when in a state establishment, described his daily routine as follows:

"I was up at 7.00am, had to wash, dress, get breakfast and then go to school. I returned from school at half past three and changed out of school uniform. We had games and would sometimes play outside. I did homework and had tea. We went off to bed at around 8.00pm after supper which was tea and biscuits."

Religious Practice

190 Seventeen of the twenty male applicants who had been in state establishments did not mention religious practice when describing their experiences. Of the three who did, two spoke positively about this aspect of their care while one believed this to be excessive and said the following:

"The officer in charge was very religious, services twice on every Sunday, Sunday school, evening catechism".

Applicants' Experiences of Discharge from the Care System

191 Seven of the twenty male applicants did not give any detail about their discharge arrangements from state establishments. Six of the twenty male applicants were returned to family care. Three of the twenty male applicants went on to find employment and accommodation. Two of the twenty male applicants were transferred to another establishment in the voluntary sector. Two of the twenty male applicants were transferred to juvenile justice establishments.

Females: State Provision

192 Ten female applicants who spoke to the Forum were placed in nine different establishments in the state sector. One of those applicants had two placements in different establishments in the state sector. One placement was made in 1959 while the other ten placements were in the

1960s and 1970s. All ten applicants were in their placements for one year or less.

Care Conditions

193 The female applicants made no complaints about food, clothing, heating, bedding and personal care. In some of their establishments provision was described as good, while some applicants did not comment at all on these aspects of their care.

194 In general, recreational facilities were described as adequate with appropriate toys or games available. Recreation, where mentioned, fitted the normal pattern for children and young people. Eight of the nine applicants in state establishments made no reference to having to complete tasks or chores. One applicant had to work in a laundry attached to her placement in the 1970s when she was in her mid-teens. She got paid a small amount for the work, which was described as arduous, and she had to pay for all her personal toiletries out of that sum.

195 Religion was not commented on by any of the nine applicants to the Forum and there was no comment in relation to medical care except for one applicant who remembered a general practitioner attending.

196 Comments from applicants included:

> "...was a lovely children's home."
>
> "It was great...we mixed together...boys and girls...we got on well... when my father came to bring us home...I wanted to stay."

Applicants in state establishments went to local schools and there were no complaints about the education they received.

Discharge from State Care

197 Four of the ten female applicants were discharged home from their placements in this sector. Three of them were transferred to placements in the voluntary sector, two left to go to hostels and working life and one was admitted to a psychiatric facility.

Juvenile Justice Provision

198 This section of the report is in two parts, the first dealing with the experiences of the male applicants and the second dealing with the experiences of female applicants who were in juvenile justice establishments.

Males: Juvenile Justice

199 Twenty-seven male applicants who spoke to the Forum had experienced 39 placements in seven individual establishments within the juvenile justice sector.

Placement Duration

200 Twelve of the male applicants had spent one year or less in a juvenile justice setting whereas seven applicants had spent two years, two applicants had spent three years and two had spent four years in a juvenile justice setting. Four applicants had spent five years in a juvenile justice setting.

Other Care Placements

201 Twenty male applicants each had one placement in a juvenile justice establishment during this period and of those:

- three had been in one or more voluntary sector establishments before their admission to a juvenile justice establishment
- one had been discharged from a juvenile justice setting and then placed in a voluntary establishment
- three male applicants had re-admissions into juvenile justice establishments.

Four male applicants had two placements each in different juvenile justice establishments. One male applicant had three placements in different juvenile justice establishments. Two male applicants had four placements each in four different juvenile justice establishments.

Reasons for Admission

202 As indicated earlier, some of the male applicants were not aware of the reasons for their placements in juvenile justice establishments. Equally, some chose not to speak of the reasons why they were sent to such establishments. Twelve male applicants said they were the subjects of court orders granted through the youth courts. The Forum heard that applicants were sent to juvenile justice establishments for the following reasons:

- truanting from school
- antisocial behaviours such as petty theft
- absconding from a children's home or running away from the family home

- out of control and challenging behaviours and assault
- breach of a supervision order.

203 Applicants gave the following information to the Forum about the reasons for their admission.

- Two applicants who had been placed in voluntary establishments previously, said they were sent to juvenile justice establishments due to persistent absconding.
- An applicant commented that the arrangements to place him in secure accommodation were facilitated by staff in the voluntary and the juvenile justice sectors, without the involvement of any external agencies or authorities.
- One applicant who was admitted as a twelve or thirteen-year-old under a court order for truanting and discharged five years later, told the Forum that he thought, at the outset, he would be detained "for a few months, not for five years." He concluded that the absence of his father resulted in him being overly punished for what was described as a relatively minor matter. He could not understand why he was sent away from his mother for such a significant length of time.
- One applicant was admitted as a fourteen-year-old under a court order "for loitering with intent" in a shop. He was discharged from placement two years later.
- One applicant was sentenced to a "period of training" after many court appearances.
- One applicant was sent by the youth courts for many minor offences such as stealing groceries after his father had deserted the family.
- One applicant was placed as an eleven-year-old by the magistrates court in response to an incident when he assaulted another child in a park.
- One applicant was sentenced to four weeks detention when he was eleven or twelve years of age.
- One applicant was sent to a juvenile justice establishment as a holding placement before he was detained in another establishment, as he was persistently absconding (this applicant had a history of three placements).
- One applicant was a member of a paramilitary organisation and charged with possession of a firearm at fifteen years of age. He was remanded for six months and then sentenced to three years detention.

Care Conditions

204 Fifteen male applicants had no memory of or did not disclose any details of the food, clothing, bedding or heating they were provided with in their placements. Seven male applicants described the food and clothing as good or adequate and one applicant described the food as very good. Four applicants who were in placement in the late 1950s and early 1960s described the food and the clothing provided to them as poor.

"We all wore short trousers."

"Absconders wore white shorts, even out on walks to mark them out."

"Rubbish clothes, short trousers or later baggy long trousers."

"Christmas dinner was a jam sandwich (no butter) and glass of milk."

Work

205 Some applicants spoke about being made to work in their establishments. The following comments are representative of what they told the Forum.

"I cleaned the bedroom and corridors; I was sent out in school holidays to pick potatoes for farmers; I was promised half-crown a day. I never saw it. I was fed by farmers when out and this was better than the food in."

"At weekends the Belfast boys went out whilst we had to clean and polish the three dormitories using blankets on our feet."

"We cleaned and polished the dormitory every Saturday."

"If we misbehaved, we were made to clean the place – we were kept out of school to do this."

"I worked in the laundry and in the kitchen; I had cleaning duties including mixing the floor wax and waxing the floors; I acted as messenger for teachers taking notes from class to class constantly; I became the personal servant of the … I worked in the vestry and the shoe-maker's shop; I worked in the gardens in the holiday home."

"I had to do the floors by walking up and down with cloths on my shoes to polish them for hours."

"I had to clean the showers."

"I had to work in a staff member's house, a mansion, where I dusted, cleaned and polished."

"I spent six months in the kitchen washing pots and pans; I had dermatitis from my hands being in water and soap all the time. The skin was falling off me."

"I worked in the shed on scrap metal; pulling spikes out of metal all day."

"I was made to scrub large stone floors with a scrubbing brush. If you didn't do as required, you got a slap on head and face."

"I had to clean toilets with a toothbrush and was hit if not satisfactory."

One applicant commented that in his opinion:

"the allocation of duties to the boys depended on whether or not staff liked you."

Religious Practice

206 Of the 27 applicants who had been in juvenile justice establishments seventeen did not mention religious practice. Ten applicants, all resident in one establishment, spoke of religious practice but this was not described as excessive. One applicant told the Forum he was an altar boy, which he enjoyed. Two applicants referred to the usual Mass on Sundays.

Recreation

207 Some applicants referred to a number of recreational opportunities including:

- two-week summer holidays
- band
- boxing and football
- swimming
- television
- football, table tennis and snooker
- hurling, Gaelic football
- half hour "association" time daily.

Medical Care

208 Most of the male applicants did not discuss medical interventions or treatment. However some applicants made a passing reference to a designated medical person, whom they understood to be a nurse, based on site and part of the staff complement. Three applicants who had been in juvenile justice establishments commented on medical attention as follows:

"I was badly injured on two separate occasions by staff. One time, I was taken to a local hospital and on the second occasion, to another hospital. Medical staff did not ask about the injuries."

"I was put in the infirmary when head-butted by another resident and I had to have my nose reset."

"I was taken to hospital for x-rays when my ribs were broken during an assault by a member of staff who beat me with a hurling bat."

Discharge from Juvenile Justice Placements

209 Eleven of the twenty male applicants were discharged home to family care. Two male applicants went to live in digs and both secured apprenticeships. One applicant commented, as an aside, that the boys who had been in his establishment were known as "bad boys" and his peers were told not to associate with him.

210 One applicant returned to his juvenile justice establishment as a day pupil to complete his education. Another spoke of the assistance he received when, at sixteen years of age, he was discharged from his placement and staff had arranged for him to commence an apprenticeship. Otherwise, applicants did not make reference to post-care support. One applicant was discharged to a voluntary establishment. Six applicants were transferred to other juvenile justice establishments and their experiences are included in Period 3 of this report.

Females: Juveniles Justice Provision

211 Seven female applicants had seven placements in two individual establishments in the juvenile justice sector. Five female applicants each had one placement in one individual juvenile justice establishment as follows:

- Two applicants were placed in establishment in the late 1950s and early 1960s. One of them was placed there for four years and her sister was placed for nine years. These two siblings entered into this placement as a result of non-school attendance.
- Two applicants were placed in the early 1960s – one applicant had a placement of three years duration and the other had a placement of two years duration.
- One applicant was placed for one year in the early 1970s.

Two other applicants were placed in another juvenile justice establishment as follows:

- One applicant had a placement of three years duration in the late 1960s.
- One applicant had a placement of one year in the 1970s.

Reasons for Admission

212 Some female applicants did not know why they were placed in some establishments. The information they gave to the Forum indicated the following in relation to placements in the juvenile justice sector:

- Five applicants appear to have been subject to a training school order. Two of those were siblings who were not attending school. One of the siblings was very young and there was no other child of similar age in that placement.
- One applicant, who had a short-term placement, appears to have been subject to a place of safety order and placed in this environment because a suitable, more appropriate placement to meet her needs was not available.
- One applicant did not know the reason for her placement.

Care Conditions

213 Five of the seven female applicants did not speak about the basic care provision facilities in the juvenile justice establishments. Two applicants, who had criticisms of the basic standards, described the food as poor. One applicant also felt that personal care was poor. Their description of the overall situation as experienced was as follows.

> "I was the youngest child there for six years. I had no friends of my own age. There was a great deal of violence and hard physical work. I was always the youngest. The food was poor at times but emotionally the place was very cold. Although I was a small child, I was not allowed by staff to get any comfort from others."

> "They had rewards points and a grade system – 90 points were required for a home visit. I was referred to by a number…We had two sets of uniform and had to change on Monday. The pants were not new when I got them. I got only three sanitary towels a day but I was not allowed to wash my pants."

Work in the Establishments

214 Six of the seven female applicants described having a heavy workload during their placements in juvenile justice establishments.

- One applicant spoke of having to clean stairs and banisters, do the laundry, and wash tiled walls using a toothbrush to clean grouting. She described being made do it all over again if the staff thought her work not good enough.

- Another described cleaning and polishing the chapel and dormitory: "Lots of kitchen work, laundry work, weeding, making up hot water bottles for staff. The girls kept the place pristine."

Others told the Forum that:

> "Work was a constant…scrubbing, washing, polishing chapel, dormitories and staff quarters. Kitchen and laundry work included washing soiled sanitary pads belonging to staff."
>
> "We had to scrub floors (there was a buffer to polish floors) we had to do knitting, embroidery and sewing and the items we made were for sale. I had to hand wash 34 pairs of knickers and socks."

Religious Practice

215 All but one female applicant spoke of religion as part of their daily life, including daily Mass, Rosaries and Confession. One applicant described her experience:

> "…I had to go to church each Sunday but we were made to sit in a segregated area… there was no mixing."

Another applicant described her experience as follows:

> "Religion 24 hours a day; seven days a week praying, chapel, retreats in silence, in classroom a lot of religion, and we were tested on catechism."

Recreation

216 Five of the seven female applicants described some form of recreational activity in the two juvenile justice establishments. This included netball teams, daily walks, dancing classes, and some time to watch television in the evenings. There was an annual holiday to a residential facility that was used by many organisations during the summer. This was described as often requiring heavy cleaning before it could be used: "we spent the first week cleaning it out." One applicant whose placement at age fifteen was for three years duration in the late 1960s spoke of locked doors and no outside play except for a hike on Saturdays.

Medical Care

217 The Forum heard from four of the seven female applicants concerning the availability of medical services in their establishments. It appears both establishments had a dedicated staff member available to deal with medical issues. This position changed over time. Two applicants attended

hospital while in their placements; one was for a routine admission while the second admission was in respect of ongoing bedwetting.

218 One applicant described how an infection was dealt with:

> "she (named staff member) was meant to look after ill girls. She put my infected finger in boiling water; that burnt two of my fingers."

Another applicant described how she cut her leg on a rusty iron post whilst on a walk and was given no medical attention and still has a deep scar from the injury. The same applicant described that she was taken to the beach and made to stay out in the sun and sustained sun burn. She had cancer in later life in the same area where skin was blistered and she noted her concern that she had been exposed to extreme heat with no protection.

219 Two applicants from the same establishment described the trauma of undergoing medical examinations on admission. These were described as extremely invasive with no explanation for what occurred before, during or after the procedure. Neither applicant was prepared for this. One had a full inspection on admission including an internal examination. The other was taken to the doctor and her legs were placed in stirrups; she was subject to a medical examination and no explanation was given. "They just did it."

Applicants' Experiences of Discharge from Care

220 Four of the seven female applicants were discharged home to parents or to relatives from their placements in the juvenile justice sector. Two applicants went out to work and lived in hostels initially, while one applicant was placed in a children's residential establishment. Three applicants reported receiving some help after leaving the system. Some of their reported experiences were as follows.

> "…they got me onto a course; I was not told about it in advance. The routine was that a case appeared; the girls would wonder who was leaving. I was called out; I had very little to leave with. I was taken to Belfast to a convent and made to go back to (her establishment) every weekend. I just walked out one day and went home; no one checked."

> "I was under supervision until I was 21 years old but the supervisor insisted on coming to work interviews and explaining my background. The supervisor was annoyed if she was not told of any change in my job or boyfriend…She interviewed boyfriends for suitability. I got married before I was 21 without permission from the supervisor."

221 Three applicants did not recall any assistance following discharge from care and their observations included:

> "There was no preparation…I was farmed out…a home girl good to scrub, clean and bleach…cleanliness was next to godliness."

> "I was playing a netball game when this person (named) came. I wasn't sure who she was but she removed me to a great aunt. I didn't know her…My family didn't want me…I had no chance to say goodbye to my friends…I never saw anyone else again."

All Establishments

222 The following sections of this report include all applicants who were placed in establishments whether designated as voluntary, state or juvenile justice provision. Included are applicants' memories of their experiences of inspections or other visits, the positive comments they made about their care and their contact with other residents or personnel.

Memories of Inspections and Visitors from Outside Organisations and Agencies

223 The majority of applicants, both male and female, had no memory of any visits by Inspectors or other personnel from either the statutory or voluntary sector charged with monitoring the provision of care afforded to them. Some applicants recalled visitors from outside organisations. However they did not always know the role or function of the visitors. Applicants believed that among the visitors some were from organisational headquarters and some were designated official inspectors from the Health Ministry, Home Office, Education Ministry or from welfare committees.

224 A common feature of inspections and official visits, as applicants told the Forum, was that the children and young people did not have opportunities to speak to visitors on their own.

> "The staff were always present, always supervising."

Male Applicants

225 Of the 125 male applicants in care, 98 gave no account of remembering any official visits. Twenty-seven applicants had some recollection of visits but most could not be certain exactly what the status of the official visitors was.

226 Eleven male applicants had some memory of an inspection and of other officials visiting the establishment in which they were placed. The following is taken from comments they made to the Forum:

> "The welfare visited regularly; they spoke to me. I never told what was going on as older boys had warned us that it would get back to staff and we would be punished."
>
> "I remember a woman visiting; I think she was from the welfare. I was always placed at the front of the line."

227 An applicant spoke about three people coming who were possibly from a Government Ministry. Untypically, he and other children were allowed to enter the sitting room where they saw toys. The children were given an extra blanket and a nice quilt. A member of staff was smiling and helping a child with a jigsaw puzzle. He said this was not the usual course of events. Once the officials left the home, the toys were immediately removed and this room became off limits to the residents again. Some of the comments made by the applicants set out below:

> "They were only with you for a few minutes before they went upstairs for the best grub. I couldn't tell them, they wouldn't have listened. They put you there in the first place; they would not admit their mistakes."
>
> "I don't remember inspections as such, but if there were any visits from people outside everywhere was cleaned including staff rooms. The dining room was set and we were not to talk. We were hidden away. When they had left, everything reverted back to normal."
>
> "If visitors came, no one from outside would ask how you were, I never saw a welfare office; if visitors did come, you were told to keep your mouth shut."
>
> "A special service took place when church dignitaries visited."
>
> "We were told 'You be on your best behaviour, we are having visitors today' but we never would know who they were."
>
> "Social workers and others visited, but the staff were always alerted. They would see children in the parlour at the front of house on the ground floor."
>
> "I remember one visit by a social worker."

228 One applicant referred to a Secretary of State visiting and enquiring about his welfare. He felt unable to talk about his care as the wardens were present. Another applicant described a visit by a Secretary of State

following a great deal of publicity and said he was taken to his cell as it was well kept. All residents were warned in advance that they would "be killed" if anyone complained.

Female Applicants

229 Sixty-nine female applicants had no memory of any inspections during their placements. Eleven female applicants had some recall of visits and recounted their experiences to the Forum as follows:

- "…they called the Inspectors 'the Ministry' but we didn't know where they were from, who they were or how to approach them." This applicant said that a concert had been arranged with Irish dancing; she recalled the children being told to say how happy they were, how good the staff were and being told to smile.
- The provision of special clothing was commented on by some applicants who said the children were given nice clothes and made to perform songs or dances for a visitor, but the nice clothes were removed once the outsider left.
- One applicant mentioned being told inspectors were due. She never knew where they were from but recalled that the night before they would be told people were coming and they were to be on their best behaviour. New things including toys, dolls and books which the children had not seen before would be brought out. However they were taken away after the people left. She wondered why the inspectors didn't pick up on children's reaction to the toys or how new they were.
- Another applicant said that it was known when inspectors were coming to the establishment: "We cleaned everywhere, the beds all dressed, new clothes…all removed when left. We were well warned to be careful how we answered questions."

230 The Forum was told about one classroom inspection:

> "The teacher….had a blackthorn stick she would use to beat us on our legs and…an inspector came into classroom…we gave the right answers to his questions. He saw the stick and asked the teacher what it was for. She lied and said it was her pointing stick; then to illustrate the point she used it as such."

231 Other visitors referred to by the applicants included a bishop, committee members and a number of groups known to the girls as "the benefactors". One applicant described one such visit as follows:

"I was coached and dressed up for benefactors calling…a couple with maybe two children. I had to stand up…I remember hating it…having to stand for children and say hello."

232 Another memory that was recounted was the visit of a film crew and an applicant recalled new toys and garden equipment put out for the occasion. The girls were warned not to ask where they came from. The applicant said everything looked brand new and was taken away as soon as the television crew left.

Applicants' Comments on Positive Experiences

233 This section covers the positive comments made by both male and female applicants who spoke to the Forum and who were placed in the care system between 1956 and 1975. Most but not all applicants to the Forum had some positive memories of their childhood in the care system.

234 Many applicants had positive memories of family visits, even if these were few. These visits were described as being closely watched by staff and they were never left alone with family members without supervision. Some applicants were allowed out to spend weekends and holiday periods with family members including extended family members and they really enjoyed this, but dreaded having to return to the establishment. Many applicants did not know their siblings and some spoke of their joy at getting to see brothers and sisters on the rare occasions when meetings were permitted.

235 Many applicants had very fond memories of families who had befriended them and who took them out for breaks as often as they were allowed. The families were not always allowed to take the same children each time but some managed to do so, while at other times it appeared to be a lottery and different children were chosen to go out. A small number of applicants spoke of their foster families' wishes to adopt them but stated that this request was refused. They said they were never told why, but one applicant recalled that her foster family was refused permission to adopt and did not return to the establishment again "…my life might have been so different."

236 Most importantly, applicants spoke of the friends they made during their childhood in the establishments; they saw them as family and spoke about the support they provided in adult life.

Male Applicants

237 Most male applicants spoke about their positive memories and experiences in the care system. Their comments included:

"(staff named) was dead on, lovely. On St Patrick's Day, he would ask you your name and if it was Patrick he gave you half a crown. One year a lot of boy's names were Patrick! He was a good member of staff who had time for you."

"The staff did their best."

"A member of staff who was working a short period of time was my saviour."

"He (a member of staff) took all in hand, made you feel important, enlightened you about your future."

"A particular member of staff was very good to me. Any money I received he would keep it for me and write it in a book and keep a record when he gave me any – he always knew how much I had because of his record book. He was an older member of staff, very genuine – it was nice to have a friend."

"Mr and Mrs...my house parents were very good to me; they cooked me breakfast...I saw them as grandparents."

"I liked this home, particularly once I was placed in the smaller units."

"One of the staff recognised me as a loner and befriended me teaching me how to play with a set of playing cards."

"I was sent to buy stamps from the post office – I really enjoyed the freedom."

"My accommodation was warm and comfortable and clean...I had my own allotment and grew vegetables."

"I enjoyed going out to stay with a family in Newtownards."

"I liked playing football in the fields in the grounds and I was taken fishing to the Skerries."

"My primary school was a fantastic place – really, really good."

"At Christmas, Easter and summertime, I was taken out by a very wealthy family...both school teachers. They bought me and another lad from the home new clothes."

"I enjoyed being taken out by a family for three weeks, three years running but then I was extremely upset when it was time to return and I always pleaded to stay. Leaving was like going from heaven to hell, crossing a line of sunshine over to pure darkness."

Female Applicants

238 The female applicants who spoke about positive memories referred to going out to foster families as being of great importance to them. Most were very appreciative of the kindness they received and spoke of being accepted and enjoying being able to be a child. A few applicants had more negative experiences and one applicant told the Forum of her mixed experience with foster families:

> "Some families were good to you but others treated you as a skivvy... like a maid not a holiday."

Another applicant talked about the anxiety of the selection process for such outings:

> "Going out was great but if I was not chosen I hated staying in...missing friends and having to do chores including cleaning the classrooms. I felt they were my family."

239 Other positive memories included:

- preparing for and taking part in the choir and annual competitions
- putting on a Christmas show for staff, Bishops and other dignitaries
- being taken on outings and holidays
- Christmas parties arranged by outside firms, "We got nice food, toys and forgot where we lived."

240 Twenty-five applicants spoke very warmly about one or more members of staff. Most often the staff members were kitchen staff or other staff who were not in positions of power in the establishments. The following comments are representative of what they said:

> "...lay care staff, a gem. They let us stay up to watch 'On the Buses' behind their back."
>
> "Very good kind staff in the kitchen."
>
> "...very kind, I only saw her in the kitchen."
>
> "...a very good, kind and gentle person but she was in the nursery."

A member of staff was referred to as a "ray of sunshine". She painted flowers on walls, found out the birth dates of the girls and had a cake for their birthdays.

241 Other applicants' comments on staff members included:

> "…she had very kind eyes. I think she understood what…was up to but she had no power."
>
> "She was a lovely considerate caring person."
>
> "She was very nice and would sneak food to us, if we were made stay in; she would let us out when she knew it was safe to do so."
>
> "They actually were interested in us."
>
> "He was the best."
>
> "The music teacher was very straight, a lovely man…he never hit anyone."
>
> "…he was very good and his classroom was a haven."

242 One applicant who was discharged in the early 1970s described the food provided as "very good" and the washing facilities as "excellent."

243 Christmas Day within some establishments was experienced as a very enjoyable time with better food and some small presents.

> "Christmas was good, the girls put on show for all the staff, no outsiders came, the staff liked you if you were doing things for them. The show had to be perfect. On Christmas Day you got an apple, an orange and sometimes a pair of slippers."

244 The Forum heard of many positive experiences from applicants placed in the smaller, community based establishments.

- One described her establishment as "one big family." She liked the co-ed set-up and all the children got on well together.
- Another said her establishment was run by a family of a different religious faith: "they were lovely people, kind to us; they never raised their voice to us. There were lots of toys there."

245 Other positive comments included:

> "I felt safe – the staff were lovely people. People were treated as human beings."

An applicant referred to the food being good, including having sausages and toast, boiled eggs and a cooked dinner on Sunday with meat, vegetables and jelly and ice cream. All the girls had to work but this was not seen to be excessive or inappropriate.

"I don't remember anything bad. Years before it may have been horrendous but although hard, I was not abused. I am a survivor not a victim."

Contact with Other Residents and Personnel Post-Care:

All Establishments

246 This section describes what male and female residents told the Forum about contact they had had with other residents or personnel after they had left the care system.

Males: Contact with Other Residents

247 Eighty-two male applicants did not discuss having any contact with other ex-residents. The remaining 43 male applicants mentioned some contact either in the past or more recently with their co-residents from the care system. For four applicants this contact was with their brothers and sisters who had also been in care. Some applicants referred to meeting ex-residents on the street or in social circumstances. A small number of applicants said they met their co-residents while serving custodial sentences. The following comments were made by applicants in regard to contact with other residents with whom they had been in care.

"I had a sequence of custodial sentences and came across some of the lads from ... in other penal establishments. I also saw some of them later when released from custody."

"I have seen a number of my contemporaries over the years, including some when I was in jail."

"I met former residents in prison in England most commonly in... Prison."

"I meet them from time to time in bars and clubs."

"I see former 'home boys' in and around Derry regularly."

"I continue to receive support from an ex-resident."

"I still remain friends with former residents."

An applicant referred to a friend whom he was very close to – they had been in care together. This friend was "like a brother" but he was shot dead soon after being discharged from care.

Contact with Personnel

248 Ninety-nine male applicants said they had no contact with any members of staff from any establishment in which they were placed. Some of those applicants commented very strongly that they had no wish ever to have any form of contact with staff. Twenty-six male applicants said they had recent, distant or ongoing contact with staff from an establishment in which they were placed. Some applicants had actively searched for staff whom they remembered in a positive light as they wished to reconnect and thank them for the kindness they had shown. Applicants made the following comments in regard to contact with staff:

> "I had contact with some members of staff whom I remember fondly."
>
> "I maintained contact with some staff who had been kind to me and I visited them when in Northern Ireland."
>
> "I have subsequently met a staff member from the home and also a former schoolmaster who helped my son at the same school as I had attended."
>
> "I visited the teacher who used to take me to his home during holidays."
>
> "When I was in my thirties I made contact with a staff member to try to get information about my family."
>
> "I visited my housemother some years after having left ... and she apologised to me for her behaviour towards me."

249 Other male applicants made reference to not wishing to have any form of contact with either their co-residents or staff. Some of these applicants chose to move away from Northern Ireland or distance themselves from their counterparts who had also been in care. A few applicants said they wanted to start life afresh and to form relationships without people knowing about their background, for example:

> "I moved to London in my late teens and have remained there ever since."
>
> "I tried to shut out all memories and wanted no contact with others."
>
> "I was gradually distanced from my siblings, a separation that was to last for many years."

Females: Contact with Other Residents

250 Fifty-six female applicants advised the Forum that they had had no contact with other residents after they left their care placements. Seventeen had some contact with other residents on an ongoing basis while seven

applicants had established contact more recently. The contact with other residents includes contact with siblings that had not been allowed or encouraged during their placements. Some comments from applicants illustrate the points they wished to make.

> "I've kept in contact with some of the other ex-residents. They were my family."
>
> "No contact was allowed in the home. If you pass another person you know had been there, you would not acknowledge each other. I am still being controlled."
>
> "I regularly attend reunions, I've welcomed other residents into my home and helped them with support…doing what some older residents had done for me."
>
> "With two siblings I attended a reunion of former residents."

Contact with Personnel

251 Sixty-three female applicants told the Forum they had no contact with personnel after they left the establishment in which they were placed. Eight applicants had some ongoing contact, while four applicants had contact in the past but not more recently. Finally, five applicants had made contact with personnel more recently. The following comments and quotations from applicants are typical of the information provided to the Forum.

> "At a reunion 27 years ago I met a teacher who used to beat me with a wooden spoon. I challenged her at the reunion and was told 'I made you a harder and stronger woman'."
>
> "I have continued to have contact with (named officer in charge) over the years."
>
> "I have been in contact with the establishment to try to get information about my siblings and family circumstances."
>
> "I have received an apology from the…for the abuse I experienced in the home they had responsibility for."
>
> "I was fond of one staff member in particular and put flowers on her grave despite all the cruel things I saw her do."
>
> "The staff and other 'laundry girls' made my wedding dress and I was married in the chapel."

One applicant summed up what many said to the Forum:

"I tried to deny ever being there…I was completely ashamed of my placement there. I felt in some way it was my fault."

Education

252 The great majority of applicants, both male and female, who attended the Forum and who were resident in establishments from 1956 to 1975 referred in some way to their education. The information they gave is summarised below.

Males

253 One hundred and nineteen of the 125 males who spoke to the Forum made some comments on their education. The great majority of them remembered their primary education whether in schools nearby or, more commonly, on-site at the establishments in which they were placed. One hundred and five male applicants were of secondary school age when still in establishments. It is notable that some males recalled that the establishment in which they were placed, and that catered for older boys aged eleven upwards, in on-site educational provision, did not provide a secondary school curriculum until the late 1960s. In those circumstances, although those applicants were of secondary school age, they were still receiving education based on the primary level curriculum. Most male applicants reported they finished their compulsory education aged, on average, fourteen or fifteen years.

254 Twenty-five male applicants told the Forum they had participated in some further education. This included attending youth training schemes or courses in colleges of further education. Some applicants went on to join the armed services where they were able to benefit from further education. A small number of applicants, who were in the care system in the 1970s, achieved good GCSE results and went on to university in later life.

255 Many male applicants expressed disappointment at their lack of educational skills and lack of qualifications arising from their educational experiences in care. They described being referred to as "dunces" and to being belittled in the school environment. Many expressed the view that teachers, on the whole, did not treat them as equal to other children in the school setting. Many of the male applicants reflected that their potential went unrecognised or was ignored within the education system.

Females

256 Seventy-eight of the 80 females who spoke to the Forum made some comments concerning their education. The majority of the female applicants had clear recollections of attending primary education, whether on-site at the establishment in which they were placed or in their communities. Slightly fewer female applicants went on to attend secondary school and the vast majority of those attended school in the community, either near their homes or adjacent to the establishment in which they were placed. The majority of applicants finished their formal education aged fourteen or fifteen.

257 Twenty-one female applicants were involved in some form of further education. Many of those had pursued educational opportunities as adults, while a small number undertook vocational training such as secretarial courses, pre-nursing courses or catering courses prior to leaving the establishments in which they were placed.

258 For a majority of female applicants, experiences at school were described as difficult. Applicants spoke of feeling and being treated differently from other pupils and many said they left school unable to read and write. Some said they devised ways of covering up their lack of education and described feelings of inadequacy because of their lack of basic skills. Many applicants expressed a view that their life chances were minimised as a result of poor education and that this left them ill-equipped for life in the outside world.

Period 3: 1976 - 1995

Introduction

259 The Forum heard from 69 males and from 34 females who were in residential establishments covered by the terms of reference of the Inquiry in the period from 1976 to 1995. One male was born in 1959, 39 males and sixteen females were born in the 1960s, 25 males and fifteen females were born in the 1970s, and four males and three females were born in the 1980s.

260 Some applicants had placements in more than one establishment and in more than one type of establishment during their time in care. Initially applicants could have been in voluntary establishments and later in state or juvenile justice establishments or they could have moved to another

establishment within the same sector, for example from one state establishment to another.

Placements for Applicants in the Care System

261 One hundred and three applicants were admitted into 47 different establishments during this period. As can be seen from the following table, of the 47 individual establishments, fourteen were in the voluntary sector, 21 in the state sector and twelve were in the juvenile justice sector. Eighteen of these establishments accepted both male and female children, seventeen establishments accepted male children only and twelve establishments accepted female children only.

Category of Establishment	Number of different establishments	Male and Female	Male only	Female only
Voluntary	14	6	4	4
State	21	11	6	4
Juvenile Justice	12	1	7	4
Total	**47**	**18**	**17**	**12**

Number and Types of Placements

262 Forty-five applicants had one placement in care, 37 applicants had two placements, eleven applicants had three placements, eight applicants had four placements and two male applicants had five placements.

Total number of placements in establishments.

Number of Placements	Male (69)	Female (34)	Total (103)
1	31	14	45
2	25	12	37
3	6	5	11
4	5	3	8
5	2	0	2

- Seventeen applicants moved from a voluntary establishment and, of that number, eight applicants transferred to another voluntary establishment, five applicants transferred to a state establishment and four applicants transferred to a juvenile justice establishment.

- Twenty-six applicants moved from a state establishment and, of that number, seven applicants transferred to a voluntary establishment, six applicants transferred to another state establishment and thirteen applicants transferred to a juvenile justice establishment.
- Fifteen applicants moved from a juvenile justice establishment and, of that number, five applicants transferred to a voluntary establishment and ten applicants transferred to another juvenile justice establishment.

The placement moves of applicants both within and between different categories of care placements were varied and complex, with fewer applicants experiencing a long term placement in one establishment than was evident in Periods 1 and 2.

Circumstances of Admission into the Care System

263 This section describes the circumstances that led to the admission into care of the 69 males and 34 females between 1976 and 1995. As noted previously, most applicants who met the Forum had little or no written information about the circumstances of their admission to care. The information available to the Forum came directly from the applicants and not from official records, as most applicants had no documentation when they met with the Forum. The following paragraphs cover the age range and length of time applicants spent in the care system in Northern Ireland.

Age at Entry to the Care System

264 The age on first admission into the care system of male applicants across the three establishment types ranged from less than one year up to seventeen years of age, with the majority of applicants aged between six years and seventeen years of age on admission. In general, on admission the older males were placed in juvenile justice establishments. Likewise, the age of female applicants on admission into the care system ranged from less than one to seventeen years of age, with the majority of applicants aged between six years and seventeen years of age. The female applicants who were admitted to juvenile justice establishments were aged between thirteen and fifteen on admission.

Duration of Placements in Care System

265 The following table shows that the largest proportion, over fifty per cent, of the 103 applicants who met with the Forum spent between two and five years in the care system in Northern Ireland during this period.

Years in care	Male	Female	Total
< 1 year	21	7	28
2 – 5 years	32	22	54
6 – 10 years	9	4	13
11 – 14 years	7	1	8
15 – 17 years	-	-	-
Total	**69**	**34**	**103**

Age at Discharge from the Care System

266 The majority of both male and female applicants were over fourteen years of age when discharged from the care system in this period as shown in the table below.

Age discharged	Male	Female	Total
<10 years	4	2	6
10 – 13 years	9	3	12
14 – 16 years	31	12	43
17+ years	25	17	42
Total	**69**	**34**	**103**

Reasons for Admission

267 From the information provided by applicants, it was apparent that the main reasons for the admission of the male and female applicants into the care system were as follows:

Reason for Admission	Male	Female	Total
Parents unable to cope	8	7	15
Abandonment	1	4	5
Court orders	50	12	62
Parents deceased	0	1	1

Reason for Admission	Male	Female	Total
Other reasons	2	1	3
No information	8	7	15
Health	-	2	2
Total	**69**	**34**	**103**

268 Most applicants did not have the exact detail of the type of court order under which they were admitted into care. The types of court orders referred to by applicants or documented in papers they brought with them to their meeting with the Forum included, place of safety orders, committal orders – fit person orders, orders for detention and training school orders.

269 The main reason given for admission into care for both males and females was that they were subject to a court order. A large number of the male applicants who were placed in juvenile justice establishments said they were sent to a secure setting because they were truanting from school or for anti-social behaviour such as assault and motor theft. Several applicants were placed in a juvenile justice unit for absconding from their establishments.

270 The second most common reason given by applicants for admission into voluntary and state establishments was that their parents were unable to cope. Some applicants said their parent(s) had a disability or illness, misused alcohol or that there was domestic violence within the family home.

271 Other reasons for admission into care included being abandoned by one or both parents, death of one or both parents, special educational needs, breakdown of fostering or adoptive placements, disability following accidents and unplanned pregnancy in teenage years.

Referral Source/Agencies

272 Two-thirds of the applicants in this period said they were referred to a residential establishment by an organisation or agency of some kind.

In summary:

- The largest number, 43 applicants, said they had been referred by social services or welfare agencies and four applicants said they had been referred by an education authority.

- The second highest number of referrals originated from the courts/ youth justice and the police. Thirteen applicants said they had been referred by the court/youth justice services. Five male applicants and one female applicant said they had been referred by the police.
- One female and two male applicants said to their knowledge, there had been no referral by an organisation.
- Thirty-three applicants did not discuss the referral source.

The information that applicants gave to the Forum about the referral sources is summarised below:

Referral Source/Agency	Male	Female
Not known/not referred	26	10
Welfare authorities	22	21
Local clergy	-	-
Courts	12	1
Police	5	1
NSPCC	1	-
Education	3	1
Total	**69**	**34**

Memories of Admission and Changes of Placements

273 This section contains some direct quotations and comments from both male and female applicants on their recollections of their admission into the care system across all three types of designated establishments.

> "I was taken there by a social worker. I believe I was seduced into accepting to go there. From my records I think staff (from first placement) wanted me to go and although the welfare department initially resisted, they then agreed."

> "My parents were alcoholics. We didn't exist to mum and dad, all they wanted was drink. A woman came in a car with no warning. The four of us sat in the car, my parents waved goodbye. We had no idea where we were going. She told us we were going to see horses on a farm, so I was excited. We went up a long driveway and staff took us in. They grabbed my arm roughly. I had never seen a nun before. There was a smell of incense. It was a very dark place. The social worker left and never returned."

"I transferred from…following my sister reporting allegations of abuse. Then I was immediately removed, made a ward of court and placed in another children's home. I was absconding frequently from there and being troublesome generally. Eventually I was sent to a more secure placement."

"We were a big family. There was constant domestic violence, my mother couldn't cope, my father was always drunk and violent."

"I was taken to court and from there to a children's home. I didn't understand the nature of a court order."

"I was admitted because of truanting and antisocial behaviour. My initial placement was for one month but that was repeatedly extended, month by month, to almost a year."

"I was transferred to…as the robbery charges were dropped but replaced with criminal damage charges because of an incident in the previous establishment."

"I was placed in…in the care unit because I had become uncontrollable at home. Although it was a 'care' placement, there was no care."

"I was given a sentence for non-school attendance. My mother was unable to get me to go to school, and following two admissions to…I was then sent to be detained in…for one to three years."

"I was admitted to…but I continued to run away and got caught when I, with others, stole a car. I was glue sniffing at this time too."

"I had three periods of admission: one for breaking a window in my school, another for underage drinking, and the last for assaulting the police when they caught me. My sentences varied from one to three months."

"I was pregnant because I was naive about sexual matters. I told a member of the family who told my mother. Mother was ill with cancer at the time, so a social worker came and took me to…I didn't know where she was taking me."

"My mother had poor health and abandoned me when I was a baby. I had mental health needs as a child and was assessed by a psychologist when in the children's home."

"When my foster placement didn't work out I ran away to (children's home) as I knew my brother lived there and that it was a good place. I was allowed to stay. My mother was still unable to look after us children."

"I was born to a single mum but reared by grand aunts until they died. Then I went to cousins who neglected me. The welfare were always involved with my family."

"My parents were alcoholics and there was domestic violence from my father. My mother left the family home and my father was unable/ unwilling to care for us."

"I was being sexually abused from eight years of age by a close relative. Social Services decided it was not safe for me to remain at home as my mother couldn't protect me."

"I remember trying to climb over the wall at...(first placement) and the social worker getting me into her car (a mini) and driving me to...I remember kicking, screaming and swearing in the back seat. I don't remember being told why I was being sent there."

"I had run away from home and was living rough. After some weeks I was caught by the police and taken to a police station first and then to the home."

Aspects of Care in the Residential Establishments

274 Overall, less than half of the applicants referred to aspects of the standard and extent of care that they received when in their placements in the various establishments. Those applicants who did, spoke about the provision of clothing and food, the standard of personal care they received and, in some cases, about the bedding and heating in their residential establishments. In relation to clothing, bedding and heating, the majority of applicants commented that they had no memory of these aspects of care or made no comments about them. Some applicants, who had more than one care placement, offered some comparisons about the provision of care between the residential establishments in which they had been placed. The views of those who did comment on aspects of care are set out in this section of the report by gender under voluntary provision, state provision and juvenile justice provision.

Males: Voluntary Provision

275 Male applicants spoke to the Forum regarding their experiences of day-to-day living within the establishments in which they were placed. Their opinions of aspects of their care conditions are set out in the tables below. In the tables the numbers refer to placements, not individuals.

Diet

276 Generally, male applicants were satisfied with the quantity and quality of the food provided in their establishments. However, applicants in seven placements were dissatisfied with the food provided, saying that it was monotonous, and applicants who had been in two other placements described food as very poor.

Diet	Voluntary Male Placements
Good	3
Adequate	13
Poor	5
Very Poor	2
Not disclosed/no memory	12
Total	**35**

Clothing

277 Most applicants who spoke to the Forum about the provision of clothing were very satisfied with what they had received. In Period 3, a clothing allowance was available for each child and greater choice of clothing was possible. The applicants' opinions of the clothing available to them are summarised in the following table.

Clothing	Voluntary Male Placements
Very Good	-
Good	2
Adequate	14
Poor	1
Very Poor	-
Not disclosed/no memory	18
Total	**35**

Personal Care

278 Applicants' comments on personal care were mixed. Approximately one third of them described personal care as being poor or very poor. Complaints related to a lack of privacy in shower areas, the lack of availability of adequate hot water and a fear of the shower area where, in some placements, abuse was a constant threat. The following table is a summary of their views.

Personal Care	Voluntary Male Placements
Good	2
Adequate	10
Poor	8
Very Poor	2
Not disclosed/no memory	13
Total	**35**

Bedding

279 An applicant described the standard of bedding in his placement as very poor, with insufficient blankets and infrequent changes of sheets and pillow covers. Generally, the applicants who made any reference to bedding were at least satisfied with the comfort and warmth of their beds. This aspect of care was not mentioned at all in relation to seventeen of the 35 placements.

Bedding	Voluntary Male Placements
Very Good	-
Good	2
Adequate	14
Poor	1
Very Poor	1
Not disclosed/no memory	17
Total	**35**

Heating

280 There were two references to the provision of good heating in the placements and twelve applicants said that the standard of heating was adequate. As can be seen in the table below, this aspect of care was not mentioned by the majority of applicants.

Heating	Voluntary Male Placements
Very Good	-
Good	2
Adequate	12
Poor	-
Very Poor	-
Not disclosed/no memory	21
Total	**35**

Work in the Establishments

281 Most of the male applicants who had been in voluntary establishments made no comment on or complaint about having to work or complete chores. Several applicants referred to having routine duties including setting and clearing tables, washing and drying dishes and keeping their bedrooms tidy, but these were not said to be onerous or excessive. A few male applicants referred to a reward system whereby they received pocket money for successfully completing their chores.

282 One applicant, who was fifteen years of age when in his placement, was made to work in the garden instead of attending school and, he believes, his education suffered as a result. Another applicant talked about changing circumstances in relation to work.

> "Work differed over time. Initially there was a big farm and older boys were kept from school to work on the farm. The farm was sold off and we got work and money for picking stones in neighbouring farms and gathering potatoes. I acted as a general handyman in the holidays when most other boys had gone home. I got paid and bought cigarettes and drink."

Religious Practice

283 No reference was made to religious practice by the majority of male applicants who were placed in care during this period. Ten applicants spoke about religious practice in their placements. Seven spoke of religion being a constant feature of their daily living. One of these placements was described by two applicants as placing a huge emphasis on religion to the exclusion of everything else. They said they were constantly told of their sin and the need to clean it away. They went to chapel before breakfast and had other forms of religious observance during the day and each week. Another applicant said the school curriculum was displaced by religious education. Two applicants mentioned attending Mass on Friday and Sunday in another establishment. In contrast, two other applicants described the religious ethos and practice as "not excessive."

Play and Recreation

284 Some applicants commented that there were limited or no play opportunities in their establishments. They referred to a lack of toys and having to play outside with little or no play facilities. Other applicants referred to a TV room, movies, excellent sporting facilities, a swimming pool, an all weather pitch, gymnasium, table tennis room, being taken out on trips and attending a disco. The following comments represent the range of information given to the Forum.

> "It was clear that play was not part of the life in this establishment."
>
> "I spent most of my free time in fields with friends; we were taken to discos near the end of our time there."
>
> "We were taken on camping trips."
>
> "The home had a dog and we enjoyed playing with it."
>
> "I really enjoyed the gymnastics there."
>
> "There were excellent sporting facilities."

Medical Care

285 Only a few of the male applicants who had been in voluntary establishments made comments about, or expressed any concerns in relation to, the medical care provided. The following are some of the comments they made.

> "I have no memory of any medical intervention. I hurt my ankle badly when I jumped from a window; it was left to heal itself. Once, I was

taken to the GP but I'm not sure when or what for. I think a social worker took me, not a staff member."

"I had psoriasis; and was told by the hospital not to have baths. But I was given baths despite medical advice to the contrary."

"I was frequently ill and left on my own in my room for four or five days. No one cared when I was there. I was taken to the City Hospital regularly by a staff member who told me I was dying. My condition was never explained by anyone."

Females: Voluntary Provision

286 Thirteen female applicants spoke to the Forum regarding their experiences of day-to-day living in nineteen placements in the voluntary sector. Their opinions of their care conditions are set out in the tables below.

Diet

287 The majority of female applicants did not make any reference to the quantity and quality of the food provided. In five placements, food was described as good or very good while in four placements the provision of food was described as poor or very poor.

Diet	Voluntary Female Placements
Good	2
Adequate	3
Poor	3
Very Poor	1
Not disclosed/no memory	10
Total	**19**

Clothing

288 Most female applicants who met the Forum did not refer to the provision of clothing in this period. In four placements clothing was described as adequate and in three it was described as poor. The lack of comment by female applicants on this aspect of their care mirrors the pattern of comment made by male applicants and possibly reflects the availability of clothing allowances and the greater choice afforded in selecting personal clothing.

Clothing	Voluntary Female Placements
Very Good	-
Good	-
Adequate	4
Poor	3
Very Poor	-
Not disclosed/no memory	12
Total	**19**

Personal Care

289 Of the ten comments made by female applicants on personal care, five were positive and five were negative. One applicant described herself as "sore from scrubbing." Another applicant spoke of being made to bath in cold water when she wet the bed, but generally the lack of comment suggests that this aspect of their care was not an issue for many applicants. The table below contains a summary of the opinions expressed to the Forum.

Personal Care	Voluntary Female Placements
Good	1
Adequate	4
Poor	4
Very Poor	1
Not disclosed/no memory	9
Total	**19**

Bedding

290 Most female applicants did not refer to this aspect of the care they received. The bedding in three placements was described as poor. These placements were in establishments in the early part of Period 3 when dormitory provision was still in use. The sleeping accommodation in that part of this Period was described as cold and lacking in adequate bedding.

The table below highlights the lack of comment on bedding expressed to the Forum.

Bedding	Voluntary Female Placements
Very Good	-
Good	1
Adequate	1
Poor	3
Very Poor	-
Not disclosed/no memory	14
Total	**19**

Heating

291 Most of the female applicants who had been cared for in voluntary establishments did not refer to the heating in their accommodation. The table below indicates the pattern of comments made. There were two references to the provision of heating as being below standard and this again refers to older establishments where long corridors and dormitory style sleeping arrangements may have made the provision of adequate heating difficult. One female applicant who had experienced multiple placements in different voluntary establishments referred to one of the establishments as a "cold, unfriendly and unhappy place" and said that she felt "hungry, cold and sore from scrubbing." She described a subsequent placement in positive terms saying, "I would go back now if I could."

Heating	Voluntary Female Placements
Very Good	-
Good	-
Adequate	3
Poor	1
Very Poor	1
Not disclosed/no memory	14
Total	**19**

Work in the Voluntary Establishments

292 Several female applicants said that their responsibilities included having to clean the premises. One applicant commented that from the beginning of her placement, she had to scrub the floor and work in the laundry. Another female applicant commented that she had to brush and scrub the floor of the home, even when she was a very young child. One applicant described a range of duties including helping the younger children to get dressed, doing the laundry for her group, especially the bed-wetters and cleaning the floors and toilets.

293 A female applicant recounted that she, along with her two sisters, had to look after the babies and toddlers. A daily routine involved having to dress, toilet and feed the younger children. During term time, the sisters had to complete their chores before having their own breakfast and then get themselves ready for school.

294 Several female applicants placed in voluntary establishments during this time told the Forum that they were responsible for significant household chores within the care establishment. Another female applicant described the duration of her placement in a voluntary establishment as "wretched years."

Religious Practice

295 Eight female applicants made no reference to religious provision during their time in voluntary establishments. Five female applicants talked of Mass, Confession and also prayers. One applicant went on a retreat and two talked of attending church on Sunday. One applicant said she felt humiliated as the children were made to walk to church in "crocodile fashion" along the street.

Play and Recreation

296 Some applicants commented that there were limited or no play opportunities and said that there were few toys and nowhere to play indoors. One applicants said they were not allowed to play: "homework after school and then early to bed." Another applicant spoke of spending her time knitting and sewing clothes for babies. Some applicants described being taken out to the local swimming pool and others referred to a TV room and occasionally watching movies.

Medical Care

297 Six of the female applicants commented on the medical care provided. Three said there was a general practitioner linked to the establishment. Two others told the Forum that they were given medication and one of these said she was misdiagnosed with epilepsy when she actually had a heart condition.

General Comments

298 Both male and female applicants who had moved from one establishment to another in the voluntary sector said the care they received varied from establishment to establishment. Some described the care system within establishments as good, while others said that the care they received was deficient. The quotations and comments that follow are typical of what those who described poor experiences told the Forum.

> "My world was gone. I have keen memories of a cold wind whistling in long corridors, darkness and no opportunity to be a child. If you acted like a child you were punished."
>
> "It was like hell in the middle of nowhere."
>
> "It was like a concentration camp. I hated the place. You were treated like an animal."
>
> "It was horrible, I was very unhappy there. I was denigrated; I was punished unreasonably and on occasions locked out in a type of solitary confinement. I can't recall any positive experiences."

An applicant said that he cried himself to sleep and he did not know why he was there. Another applicant referred to feeling very isolated as he had no one to turn to.

299 Some of the applicants were placed in a large establishment with chalet style accommodation and a house-parent staff model. They referred to the house parents taking responsibility for general household tasks and one said "the home was good" and "I really liked this home."

300 One applicant who had been placed in two establishments made comparisons between both placements commenting:

> "In the second you were treated with kindness, showered with attention and food, unlike the first."

Some applicants commented on the differences in staff behaviour within the same establishment noting that some staff were good but others were not. One applicant said several times that he was very happy in the establishment but qualified this by saying "except for the abuse."

301 One applicant reflected that he felt well cared for and respected. Another applicant said he really enjoyed the place and the freedom. He said that the residents were allowed to go out and they were taken for trips in the minibus. One applicant said:

> "It was such a relief – like a holiday camp" and another stated that it was a "real escape from the abuse suffered at home with my parents."

Males: State Provision

302 The male applicants who in total had experienced 32 placements in state establishments in this period said little about the nature and adequacy of their care. The information they provided on aspects of their care is set out in the following paragraphs.

Diet

303 Seven applicants considered the food provided in their placements to be adequate or good. There was no reference to this aspect of care in respect of 25 placements.

Diet	State
Male Placements	
Good	2
Adequate	5
Poor	-
Very Poor	-
Not disclosed/no memory	25
Total	**32**

Clothing

304 Comments about the provision of clothing in 24 of the 32 placements in state provision were few. In one placement the clothing provided was described as poor and in seven others it was described as adequate or better.

Clothing	State
Male Placements	
Good	2
Adequate	5
Poor	1
Very Poor	-
Not disclosed/no memory	24
Total	**32**

Personal Care

305 Few comments were made by male applicants about the standards of personal care in respect of 24 of the 32 placements in state sector establishments. Six of the establishments were described as providing adequate or good care while provision in two establishments was described as poor.

Personal Care	State
Male Placements	
Good	2
Adequate	4
Poor	2
Very Poor	-
Not disclosed/no memory	24
Total	**32**

Bedding

306 No comments were made to the Forum about the provision of bedding in 25 of the 32 placements in state provision. Four placements were described as good or adequate and bedding was described as comfortable. In three of the placements, the provision of bedding was described as very poor.

Bedding	State
Male Placements	
Good	1
Adequate	3
Poor	-
Very Poor	3
Not disclosed/no memory	25
Total	**32**

Heating

307 Four placements were described as having adequate or good heating. There was no comment made about heating in the other 28 placements in the state sector.

Heating	State
Male Placements	
Good	1
Adequate	3
Poor	-
Very Poor	-
Not disclosed/no memory	28
Total	**32**

Work in the Establishments

308 The male applicants who had been in state establishments made no mention of having to work. Three applicants referred to having to complete routine tasks such as cleaning shoes and laying the table, but these were not described as excessive or onerous.

Religious Practice

309 None of the applicants in state sector care made any comment or complaint about religious practices.

Play and Recreation

310 Male applicants who commented on play and recreation spoke of having access to a pool table, a playground, a trip to an amusement park and being taken swimming.

Medical Care

311 No comments or complaints were made about medical care. Five male applicants said they had placements in a medical facility. One male applicant referred to dental care.

Females: State Provision

312 The female applicants who spoke to the Forum had been in 26 placements in the state sector provision. The following paragraphs outline the information they provided to the Forum on aspects of their care.

Diet

313 The majority of female applicants who were in placements in the state sector did not comment on the food provided. The food in seven placements was described as adequate or good whilst in four placements the food was described as poor or very poor.

Diet	State
Female Placements	
Good	4
Adequate	3
Poor	2
Very Poor	2
Not disclosed/no memory	15
Total	**26**

Clothing

314 The large majority of female applicants did not comment on the clothing provided in their placements. The seven who did described the standard of clothing as adequate or good.

Clothing	State
Female Placements	
Good	4
Adequate	3
Poor	-
Very Poor	-
Not disclosed/no memory	19
Total	**26**

Personal Care

315 The majority of female applicants who were in placements in the state sector did not comment about their personal care. The standard of provision in nine placements was described as adequate or good whilst in three placements personal care was described as poor or very poor.

Personal Care	State
Female Placements	
Good	6
Adequate	3
Poor	2
Very Poor	1
Not disclosed/no memory	14
Total	**26**

Bedding

316 Most female applicants who were in placements in the state sector did not comment on the standard of their bedding. The quality of provision in five placements was described as adequate or good whilst the provision in one placement was described as very poor.

Bedding	State
Female Placements	
Good	3
Adequate	2
Poor	-
Very Poor	1
Not disclosed/no memory	20
Total	**26**

Heating

317 The majority of female applicants who were in placements in the state sector did not comment on the provision of heating. The standard of heating in five placements was described as adequate or good whilst in respect of one placement it was described as poor.

Heating	State
Female Placements	
Good	4
Adequate	1
Poor	1
Very Poor	-
Not disclosed/no memory	20
Total	**26**

General Comments

318 Comments made by female applicants about their placements in state provision varied widely with some describing the placements as very cold and lacking in human kindness while other applicants said that they had no concerns regarding their care in a placement, describing it as "superb" and saying that they had "no complaints."

Work in the Establishments

319 Three applicants referred to having to complete routine chores such as making beds, assisting with cooking and preparation of the dining room for meals. None of these applicants described the allocated tasks as excessive and no one referred to being made to work for their establishment.

Religious Practice

320 None of the female applicants in state sector care made any comment or complaint about religious practices.

Play and Recreation

321 The female applicants spoke of visiting the cinema and other age-appropriate activities. Some applicants who had previously experienced placements in larger establishments spoke of the pleasure of having more freedom in smaller state establishments to which they had been transferred.

Medical Care

322 There were no comments or complaints made about medical care. Two female applicants said they had had placements in a medical facility. One female applicant said she was taken to see a child psychiatrist. She was unclear as to why that consultation had occurred.

Aspects of care in Juvenile Justice Provision

323 The first part of this section summarises the comments about aspects of their care that male applicants, who had been in 62 placements in the juvenile justice sector, made to the Forum. The second part of this section summarises the comments about aspects of their care made to the Forum by female applicants who had been in 20 placements in the juvenile justice sector.

324 Juvenile justice provision accommodated young people who were less than eighteen years of age. Most of the applicants who met with the Forum were sent to these establishments under a court order for a specified period of time. Applicants described the juvenile justice establishments in which they were placed as being largely single gender units, but there were some applicants who were placed in mixed gender units.

Males: Juvenile Justice Provision

325 One third or less of male applicants spoke to the Forum about their experiences of day-to-day living within the establishments in which they had been placed as children. Their opinions of their care conditions in the 62 placements are set out in the table below.

Aspects of care	Good	Adequate	Poor	Very bad	No memory/ not disclosed	Total placements
Food	7	12	4	-	39	62
Clothing	1	9	3	-	49	62
Heat	1	5	-	2	54	62
Bedding	4	10	2	1	45	62
Personal care	1	9	6	5	41	62

As is evident from the table, the majority of applicants did not discuss any aspects of their care in juvenile justice establishments. Many of their placements were of short duration and where negative comments were made about aspects of care, for example, personal care, these related to a perception that the shower area was unsafe because it was an area where males were susceptible to being attacked either physically or sexually. Applicants who described poor clothing referred to having to wear uniform-style clothing belonging to the establishment that could identify

the applicants. Those who spoke about inadequate bedding referred to single cell units, used as isolation accommodation, where mattresses were on the floor and bedding was limited.

326 In summary, two thirds of the applicants in juvenile justice placements made no comment in relation to clothing, food and personal care. A number of applicants described the care provision in their placements as good or adequate. Other applicants described their experiences of being in care very differently. One applicant said that "the law of the jungle reigned" and another applicant said that it was "very disciplined, like a concentration camp, a cruel place." Another applicant expressed similar views: "It was a sectarian aggressive regime ruled by violence, a cold harsh regime, very harsh and unsympathetic, and violence by staff and other residents was the norm."

Work in the Juvenile Justice Establishments

327 Most male applicants in juvenile justice placements did not refer to being made to work for their establishments. The male applicants who did refer to work said they had to clean their cells to a high standard and talked of having to repeat the task if the result was deemed to fall below the required standard. A few alleged that fault was deliberately found by staff and, perversely and provocatively, some staff criticised the cleaning and insisted on it being re-done even when it was satisfactory. Other applicants recounted that they were made to do the following chores:

- scrub metal buckets
- clean pots
- prepare vegetables in the kitchen
- look after livestock
- work as an orderly.

328 Some of the work that applicants spoke about may have been part of a vocational training programme, for example, bricklaying, car mechanics, carpentry and gardening.

Religious Practice

329 One male applicant spoke of having to attend chapel every morning where the sermons were always on the perils of breaking the law and being a bad person. Two other applicants spoke of attending Mass and one of them said that there was only a Bible to read in the solitary confinement accommodation.

Recreation

330 The male applicants who commented on recreational facilities and activities mentioned cycling, football, swimming, snooker and pool, a camping trip and a recreation room with a radio in it. One applicant described the facilities in his placement as being very limited saying "I walked about like a dog in a cage." Two others spoke of physical education being used as a punishment and having to do a military-type drill.

Medical Care

331 Three male applicants spoke about being admitted to hospital as the result of drug overdoses. Two applicants who had self-harmed stated that the staff had been instructed not to call for an ambulance. Three male applicants complained that they were not taken to hospital or did not receive medical treatment when they felt it was required, for example, following an assault by another resident or when stitches were required for a wound near an applicant's eye following an assault by a member of staff.

332 Several applicants commented that there was an on-site nurse/matron. One applicant said that he was escorted to the doctor by four members of staff. One applicant said that the residents were given a medical examination on admission and were made to strip. One applicant said he saw a psychologist during his time in his placement.

Females: Juvenile Justice Provision

333 Female applicants spoke to the Forum about their experiences of day-to-day living in the establishments in which they had been placed. Their opinions of their care conditions in the twenty placements are set out in the table below.

Aspects of care	Good	Adequate	Poor	Very bad	No memory/ not disclosed	Total placements
Food	-	5	4	2	9	20
Clothing	-	6	1	-	13	20
Heat	-	3	-	-	17	20
Bedding	-	3	4	2	11	20
Personal care	-	5	3	3	9	20

As is evident from the table above, the majority of applicants did not discuss any aspects of their care in juvenile justice establishments and those who choose to speak about care conditions said they were adequate. In two placements, the food was described as "disgraceful" and poor bedding was spoken of in the context of isolation rooms. The regime was described as harsh and cold with very strict conditions and limited liberty within the establishment, which most young females found very challenging. One applicant spoke of her humiliation when on admission she was made to undress and provided only with paper undergarments and a gown. She advised the Forum that she was offered no explanation as to why this was necessary.

Work in the Establishment

334 Female applicants in the juvenile justice sector recounted being made to clean and polish the floors on their knees. Some of them said they had to work in the kitchen. One said that

> "the staff didn't have to do any work as the girls were doing all the cooking and cleaning."

Other applicants spoke of undertaking chores, including one who commented that there was a cleaning rota and the chores had to be completed before attending school. Another applicant said she had to prepare her own meals as part of her "leaving care plan." One applicant said she had to work in the stitching room.

Religious Practice

335 One female applicant said there were prayers in the chapel before school and Mass every Sunday. One applicant said she was not in favour of having to attend Mass but did so in order to receive her daily allowance of five cigarettes.

Recreation

336 Three female applicants said there was no games room. Other female applicants said there was a television for residents and they were taken to a swimming pool and to the cinema.

Medical Care

337 Five female applicants spoke of being admitted to hospital, in two cases as a result of taking an overdose of drugs. Two applicants who had self harmed stated that the staff had been instructed not to call for an

ambulance. The establishments were described as having a designated person on the premises who dealt with most medical requirements.

All Establishments: Inspection, Positive Experiences, Experiences of Discharge from Care, Contact with Others, Education

338 This section covers the experiences described by applicants in establishments in all three types of provision: voluntary, state and juvenile justice in Period 3, 1976 to 1995. It covers the following areas: inspections and other visits and positive comments made by applicants in respect of establishments in which they were placed.

Memories of Inspection and Visits from Outside Organisations and Agencies

339 Most applicants had no recollection or did not speak of their memories or recollections of visits from people who came from outside the establishment.

340 Three applicants, two males who had been in juvenile justice establishments and one female who had been in a voluntary establishment, referred to Inspections. One of the male applicants referred to inspectors coming and to the usual routines being changed. For example, the residents would normally get their breakfast from a hatch and when finished would put their leftovers in the "slop bucket" but, when the inspectors came, the staff removed the plates from the residents' tables. This applicant said that members of staff were always present when the inspectors were on site and the inspectors did not speak with the residents. The other male applicant referred to the board of visitors coming to the establishment and asking residents if everything was satisfactory. He alleged that members of staff had warned the boys in advance of the inspectors' visit, that they would be "beaten to death" if they spoke to inspectors about what was going on in the establishment.

341 A female applicant explained that she was around twelve years old when she saw social workers for the first time and they visited her every three months. However, she said she felt that no one cared and she was not allowed to talk about life in the establishment. She spoke of visitors/inspectors and having to read for them and sensing that she was chosen as she was an attractive child who could be put forward to bring credit to

the establishment. This applicant said that the establishment was always cleaned before any outsiders arrived. She recounted that none of the visitors spoke to her and she was not allowed to speak to them and the staff were always present.

Positive Experiences

342 There were many positive comments made by applicants who met with the Forum in respect of the establishments in which they were placed. These are set out below by establishment type.

Males and Females: Voluntary Establishments

343 Most applicants did not recall or refer to any positive experiences in their placements. The others who did spoke of staff working in the establishments, visits by family members, activities such as sport, trips and outings and weekend contacts with family members. Some applicants regarded their placement in an establishment as, overall, a very positive experience. The following is a selection of the applicants' comments with some quotations.

- An applicant described a member of staff as "brilliant" and said that she got on well with her.
- Another described a member of staff as "an angel, a great woman, a brilliant woman – care was good when you were in her group."
- One named a volunteer who was excellent and always kind, as was her teacher at school.
- One applicant recalled that the staff and residents were kind to her. She remembered being spoilt as the older people in an adjoining care facility would insist that she have some of their food and told her "you need this more than me."
- An applicant identified a member of staff as a positive, caring woman who would give the boys a cuddle. He thinks she was aware of the abuse he was experiencing as she said to him "They will be caught and pay for this one day." He excused her for not telling because she was an older woman and, he concluded, her job would have been at risk.
- One spoke of a senior member of staff who was great but unfortunately left.
- Another described a number of people as "good" including an older boy whom he said "looked out for you" as did a gardener and a maintenance man.

- Another stated that many of the staff were very good, but said that it was those who were in a religious order who caused most concern.
- Another applicant said that "there were some fantastic members of staff in there who would do anything for you."
- One applicant looked forward to his parents' visits although he said that they were very rare.
- An applicant spoke of having good friends among the other boys.

344 Other applicants referred to the enjoyment they experienced in the production of a Christmas play and being part of the production team, playing with the dog and playing on a boat in the garden of the establishment. Some appreciated being taken on fishing trips by a member of staff who was "like a dad", and one remembered liking football, having a good maths teacher and getting two 'O' levels; another applicant spoke of having the opportunity to go on a six week trip to the USA.

345 Some said that they were allowed to attend the disco in a neighbouring village and another applicant, in addition to the disco, mentioned holidays in a seaside town and a visit from a celebrated footballer. An applicant described one establishment as:

> "a fantastic place, fantastic team, amazing. I loved this home – I loved it so much that I didn't leave until I was eighteen and a half years old when I should really have left when I was eighteen years old. I would go back now if I could."

Males and Female: State Provision

346 Most applicants who had been placed in state establishments made no reference to positive experiences in their placements. The minority who did spoke warmly about certain members of staff, contact with family, friendship with co-residents, organised activities and weekend leave. A female applicant said that the senior member of staff in her establishment was very good and explained that the children received an allowance for clothing, were allowed to have a friend around from school and could go into town to shop. Another applicant spoke warmly about the teaching staff and a carer she described as firm but kind. One applicant became so fond of the senior staff in the establishment who showed him warmth and affection that he visited them some years later. Some applicants spoke favourably in relation to most of the staff in their establishments. One female explained that a couple of staff were her favourites and said "they did not abuse you." One applicant commented that:

> "the care staff were nice people…all local; they were elderly but did not appear to really understand the needs of those placed there."

She described them as being like "nice grandparents."

347 An applicant was thankful that all the children in his family were placed together in an establishment. His brothers were in the same room and his sisters in a separate room but nearby. He described the placement as "a saviour for us all." He said that they were given a clothing allowance, permitted to help themselves from the fridge and given pocket money. Another applicant liked receiving pocket money and having weekly outings.

348 One applicant said that they looked forward to going home on weekends but hated returning to the establishment. Another applicant spoke of being very settled in her placement and had no complaints, whilst another said that the children in his establishment appeared to be allowed to have a more "normal" teenage life: "I liked it." One applicant referred to being moved from one establishment to another and said that the second establishment was "a gift" in comparison to the other.

Male and Female: Juvenile Justice Establishments

349 Most applicants did not mention any positive experiences in their placements. The following comments and quotations are illustrative of the information provided by those who did. An applicant complimented two of his teachers saying they were "gentlemen and good teachers." Other applicants described the staff as follows:

> "…firm but kind; most of the staff were very good and caring, supportive."
>
> "…some of the staff were 100 per cent, dead on, brilliant, very good to me, kind and helpful, got me through."
>
> "…great, dead on. One member of staff was good, gentle as a lamb and another was a lovely man."

350 A male applicant commented that his mother would come and visit him and that the teachers were good. One applicant referred to feeling positive when he had his own bedroom – proper food, a quilt that he described as "fresh", he ate at proper times and liked the "smell of cleanliness". He was excited at having a structure to his day. One applicant described positive experiences as follows:

> "I was able to settle. There were good staff, I made friends, I had sporting opportunities, I got home at weekends, I loved the food in

there and went back for seconds. Seven cigarettes a day were issued plus some extra cigarettes given personally by staff."

An applicant spoke of "some decent staff" but felt that when she found staff she could trust, they seemed to be moved away. One applicant said that she:

"loved it, the best place ever. The staff were so good to you, the nuns were brilliant, completely different – I cried when I left. I am still in contact with them."

Another applicant felt that the nuns liked her because, she believes, she was so "brutally honest." One described the staff in one establishment as being "good people"; it was "a respite" from a previous placement as there was no abuse.

351 A female applicant said that her mum would visit every two weeks and because she was one of the youngest and smallest residents, the older girls "treated me as the wee sister they never had." Two members of staff she described as "good" would also take her out. Other applicants also mentioned visits as positive memories. For example, one said his mother, brother and his girlfriend would visit him "I liked that place." Another referred to her dad visiting every Saturday when she would be taken shopping for clothes. One applicant said that visits home during some holiday periods such as Christmas and Easter were especially positive memories. Some applicants enjoyed being allowed to go home on occasional weekends. One explained "you were allowed to go home providing you had not misbehaved." An applicant who had experienced abuse acknowledged that "there were some good times in the place."

Experiences of Discharge from Care and Post-Care Support from all Establishments

352 In this period several applicants had more than one placement so their discharge from one establishment was often into another placement. Final discharge for most applicants was to their own family.

Male Applicants

353 Only five of the 69 male applicants spoke about the post-care support provided for them. The remaining 64 applicants said none was available or did not mention it. Two of the male applicants spoke of ongoing support and contact with their social workers for some time after they were

discharged from care. One was provided with a flat in the community and the other had a job arranged for him by his probation officer. The following comments illustrate different experiences in the post-care period.

> "I was collected by a male social worker. I'd never seen him before and prior to that I didn't know I was going home. I've no memory of any preparation for going home. When I got there, I discovered a new brother and sister."

> "When I reached school leaving age I moved into foster care for about six weeks. From there I went back to my grandfather and stayed for a few months and then moved into digs in the nearest town. I got a place on a youth training scheme and on the way to a job interview I heard my father had died. I went into depression, became homeless and ended up in a refuge for alcoholics."

Female Applicants

354 Many of the female applicants returned home or went to foster families on their discharge from voluntary care provision. The following points illustrate what they told the Forum:

> "I returned to the family without any further assistance."

> "I was unprepared for independent living."

> "I received no support having left the establishment; I was just gone."

355 Two female applicants referred to ongoing support and contact with their social worker and from staff in their establishment, which continues to the present day. Three females talked of being provided with a flat; one of these also received a £1,000 leaving care community grant. The other two applicants were found places in community accommodation. Two had also been given some basic items, for example, a towel and some food which they considered very limited, and they commented that they received no money. They were unable to cook or manage money and found the accommodation frightening because of the behaviour of some of the other residents.

Contacts with Other Residents: All Establishments

356 For the majority of applicants from this period it is unknown what, if any, contact they have had with other residents after leaving an establishment. Very few details were provided but just over twenty applicants said they had contact both recently and in the past with former residents. Some of the applicants mentioned contact solely in the past: ten said they had only

had contact recently; twenty said they had had no contact at all. Others made no mention of contacts. Most often, the contact that applicants had with other former residents was contact with their siblings with whom they had been placed into care.

Contact with Other Staff and Personnel: All Establishments

357 Very few applicants mentioned having contact with staff or personnel from the establishments in which they had been placed. In some cases, where they had had contact, this had been a chance meeting, for example where the person lived in their local area or the meeting had been in relation to a court case. One applicant mentioned a former member of staff who used to visit him when he was in prison and with whom he would meet occasionally for lunch after his release.

Chapter 5:

Chapter 5: Applicants' Experiences of Abuse

Introduction

1 The definitions of abuse, including neglect, as set by the Inquiry are as follows:

> "Abuse was behaviour which either (a) involved improper sexual or physical behaviour by an adult or another child towards a child; or (b) in the case of emotional abuse, was improper behaviour by an adult or another child which undermined a child's self-esteem and emotional well-being, such as bullying, belittling or humiliating a child; or (c) resulted in neglect of the child; or (d) took the form of adopting or accepting policies and practices, such as numbering children or ignoring or undermining sibling relationships; which ignored the interests of the children."

2 It is important, when reflecting on the applicants' accounts of the residential care they had received as children in designated establishments, to be aware of the different contexts and ways in which they experienced the abuse they allege. Emotional abuse, although for some applicants a matter of a one-off incident, was, according to many others, the outcome of recurring denigration or intimidation by care staff and/or other residents. Physical abuse was reported similarly, in other words as something that more often was ongoing than one-off and perpetrated by staff and other residents, although individual extreme incidents were alleged. Sexual abuse, for some participants, was an individual incident and for others ongoing; the alleged perpetrators included care and ancillary staff, teaching staff and other residents. Neglect was cumulative in its effects and not often referred to as the outcome of an individual occurrence. References to neglect touched on aspects of continuing care within the establishments and the nature and appropriateness of the education they had received.

3 Chapter 5 sets out the abuse that the 428 applicants who met with the Forum allege occurred when they were placed in the care of designated establishments in Northern Ireland from 1922 to 1995. There are three main parts to this chapter namely: abuse that occurred in establishments that were provided by the voluntary sector, abuse in establishments provided by the state sector and finally abuse in establishments that were within the juvenile justice sector. The abuse is described in three broad periods:

- Period 1 – 1922 to 1955
- Period 2 – 1956 to 1975
- Period 3 – 1976 to 1995

Period 1: 1922-1955

Introduction

4 This section of the chapter sets out the experiences of 47 male and 25 female applicants when they were placed in the care of 23 establishments in Northern Ireland from 1922 to 1955. The section is divided into three: abuse alleged in voluntary establishments, abuse alleged in state establishments and abuse alleged to have occurred in juvenile justice establishments. Each part of this section describes the experiences of the male and female applicants separately.

Abuse in Voluntary Establishments

5 Thirty-six male applicants spoke of abuse in six voluntary establishments. They did not necessarily use the terms adopted in this report to distinguish between the different types of abuse, but rather spoke of what they experienced as part of the narrative they gave in describing their childhood in designated establishments.

6 Twenty-four female applicants spoke of abuse in six voluntary establishments. As with their male counterparts, most of them described experiences that included one or more types of abuse. Only three female applicants reported sexual abuse, whereas fifteen of the male applicants alleged they were sexually abused.

7 A small minority – including some of those who left Northern Ireland as young children to travel to Australia through the child migrant scheme – had no memory of their care in voluntary establishments in Northern Ireland and no recollections of the kinds of abuse that many of the others described. For those who were sent to Australia as young children, and indeed for those who were older when they left Northern Ireland, their concerns related to the selection process for Australia and how separation impacted on their parental, sibling and extended family relationships and on the friendships they had developed in their establishments in Northern Ireland. Some applicants also commented that in addition to the separation from loved ones, the loss of cultural identity compounded their feelings of anxiety.

Types of Abuse:

Males: Voluntary Provision

8 The thirty-six male applicants who had been cared for in voluntary establishments referred to one or more types of abuse when speaking to the Forum. The combinations of types of abuse and the number of applicants who reported these are summarised in the table that follows.

Combinations of Abuse Types	Males	Establishments
Physical, sexual, emotional and neglect	7	4
Physical, emotional and neglect	9	3
Physical, sexual and emotional	5	2
Physical, sexual and neglect	-	-
Physical and neglect	2	2
Physical and emotional	3	2
Physical and sexual	3	2
Emotional and neglect	-	-
Emotional and sexual	-	-
Emotional, sexual and neglect	-	-
Emotional	4	1
Sexual	-	-
Physical	2	1
Neglect	1	1
Total	**36**	**6 different establishments**

9 The same establishment was named by eighteen of those alleging abuse. Physical abuse was alleged by each of those applicants, in addition to other forms of abuse or neglect. Another institution was named by thirteen of those alleging abuse in respect of one or more types of abuse or neglect. Physical abuse was alleged by nine of those applicants, in addition to other forms of abuse or neglect.

10 It is important to emphasise that the table above at paragraph 8 does not indicate the number or frequency of individual incidents of abuse or neglect but, rather, the total number of times particular types of abuse or

neglect were mentioned by the male applicants in their meetings with the Forum.

Physical Abuse

11 Thirty-one of the men who had been cared for in voluntary establishments in Period 1 reported that particular members of staff were persistent, vicious and wilful in hitting them. There were:

- Twenty reports of physical abuse in one establishment
- Six reports of physical abuse in another establishment
- Two reports of physical abuse in a third establishment
- Three reports of physical abuse, one in each of three establishments

Descriptions of Physical Abuse

12 Various means of inflicting pain were mentioned by applicants, including the flat of a hand, a fist, a bunch of keys, a cane, a stick, the leg of a chair, a broom handle, hurling sticks, feet, a leather strap and a belt. Added to these were allegations that some staff pulled boys by their sideburns; four members of staff were said to have lifted boys that way and also by their ears. Throughout their accounts of the physical abuse they reported, the applicants referred to it being intended as a punishment for a misdemeanour on some occasions and on others as gratuitous violence by people – care staff and older boys – who were out of control.

13 One man said that the beatings he received from a member of the religious care staff began when he moved into the "juniors section" from the nursery. He said he was beaten constantly by this person – "she took a dislike to me" – and beaten occasionally by other religious care staff. He added that the instruments used to beat him included the leg of a chair. Another man, referring to the same member of staff, said that he was beaten with a stick "a bit like a billiard cue", and that she used her belt to beat him and other children on the head. The same member of staff was reported by another applicant as using a bunch of keys to strike the children and, from time to time, this resulted in cuts and bruises. He added that when the local parish priest called and noticed the injuries, he told the religious care staff that this practice had to stop.

14 Several men spoke of being beaten on the bare buttocks with a stick by religious care staff, sometimes for bed-wetting and on other occasions, as far as they were concerned, for no reason at all. One reason given for a beating was that the applicant as a young boy had been found in bed

without his hands crossed on his chest, the required position for sleep as far as care staff were concerned. He said that the older boys would check for this kind of forgetfulness and punish the younger boys accordingly.

Physical Abuse by more than one Person

15 Twenty-nine of the men who reported physical abuse indicated the following:

- Twenty-one reported abuse by one person.
- Four reported abuse by two people, either separately or concurrently.
- Two reported abuse by three people, either separately or concurrently.
- Two did not identify how many people were involved in their abuse.

The Roles of Alleged Abusers

16 Applicants who recounted physical abuse were able to recall the roles or status of those who had abused them. The majority of those referred to were members of the care staff and, in most instances, were members of a religious order. It is noteworthy that of the total of 31 alleged abusers, 22 were members of a religious order or clergy. The details recalled by applicants are set out in the following table.

Roles of Alleged Abusers	Male	Female	Members of Religious Order/ Clergy
Officer in charge/authority figure	-	7	7
Care staff	2	14	15
Teacher/instructor	1	-	-
Former resident	-	-	-
Other resident	7	-	-
Visitor	-	-	-
Ancillary worker	-	-	-
Totals	10	21	22

Physical Abuse by Older Boys

17 Seven of the male applicants also described the rough treatment they received from older boys who, they said, had been given responsibility by the religious care staff to look after them at certain times of day. The applicants alleged that the older boys slapped, punched and kicked them,

all in the guise of ensuring that they were behaving properly and punishing them when they considered it necessary. None of the applicants could remember any of the religious care staff intervening when older boys punished – or attacked – younger boys physically and in excess.

Sexual Abuse

18 Fifteen of the men who had been in voluntary establishments reported being subjected to sexual abuse. There were ten reports of sexual abuse in one establishment.

19 The abuse they alleged was perpetrated by officers in charge/authority figures, care staff, ancillary staff and by other, usually older, residents. Some experienced sexual abuse as young children, others when they were in their teenage years and almost all of them witnessed sexual abuse of other children or knew of this happening in their establishments. Some of the older boys (fifteen to twenty-year-olds) who were alleged abusers, were said to be former residents who had been kept on by some establishments to work in laundering, baking, farming and general maintenance. One applicant described one of these boys as not being the full shilling. A few of the applicants also spoke of former residents being able to come back to what had been their establishment and having free access to the premises and children, including after bed-time when they also had opportunities to abuse the children.

The Types and Extent of Sexual Abuse

20 The fifteen male applicants who recounted sexual abuse reported this abuse in combination with other types of abuse. None reported sexual abuse on its own.

21 The types of sexual abuse referred to ranged from witnessing abuse to anal rape. The full range of types and number of reports of sexual abuse by establishment are set out in the following table.

Types of sexual abuse	Number of Reports*	Number of establishments
Anal rape	5	3
Coercive peer abuse	4	2
Grooming	1	1
Inappropriate fondling	4	2
Masturbation of alleged abuser by child	2	2

Types of sexual abuse	Number of Reports*	Number of establishments
Masturbation of child by alleged abuser	1	1
Oral genital contact	2	2
Witnessing abuse	4	3
Other	2	2

Note: "Reports" relates to the number of references to abuse made by applicants during their meetings with the Forum rather than to the number of individual instances of each type of sexual abuse which, for some applicants, allegedly occurred weekly for several years.

22 The sexual abuse described by applicants occurred in a number of places including dormitories, toilets, sheds, boiler houses, changing and shower areas. The types of sexual abuse reported included genital fondling, masturbation, oral sex and anal rape. For some applicants, the sexual abuse incidents were few but for most the abuse was ongoing.

23 One applicant, who found it very difficult to discuss the details of his abuse and became very emotional as he tried to describe what happened, said that he was abused by "a bloke who worked in the sewing room" who made him masturbate him. The man also took him to the showers, made him strip and beat him severely with a sally rod. Another applicant described being stretched on a laundry rack and being anally raped by older residents and by a priest attached to a local parish. Others referred to genital fondling, masturbation and anal rape by care staff and older residents and indicated that these practices occurred frequently and were well-known to other children. One man said that he was sexually abused "by various people" and that the assaults took place "in the home many times." The applicants conveyed an impression of some establishments where sexual abuse – as well as emotional and physical abuse – was endemic, part of everyday life for some children.

Sexual Abuse: Roles of Alleged Abusers

24 Those referred to as abusers included other residents, with care staff and ancillary workers and a visiting priest also being mentioned. Five of the seven adults mentioned as abusers were members of a religious order.

Roles of Alleged Abusers	Males
Officer in charge/authority figure	2
Care staff including ancillary	4
Teacher/instructor	-
Former resident	-
Other resident	9
Visitor	1
Total	16

Emotional Abuse

25 This section of the report refers to emotional abuse that was alleged to have been experienced in voluntary establishments in the period from 1922 to 1955. Emotional abuse covers a range of actions and inactions that deprived the applicants of family and sibling contact, knowledge of their own identity, affection, approval and protection from harm. In their descriptions of emotional abuse, applicants most often referred to practices and routines, such as the separation of siblings, the removal of personal belongings and not being treated as individuals, all of which affected them deeply.

Nature and Extent of Emotional Abuse

26 Twenty-six of the male applicants made 28 reports of emotional abuse. There were:

- Fifteen reports of emotional abuse in one establishment
- Eleven reports of emotional abuse in another establishment
- Two reports of emotional abuse – one in each of two other establishments.

27 The applicants described a number of factors that may have contributed to the emotional abuse they said they experienced. One of the main factors was the fear engendered by the threat of physical punishment and abuse from staff and older boys. In the latter case they spoke of bullying and of "a free rein" being given to the older boys who were placed in charge of the younger boys. They said that life for younger boys was characterised by a sense of threat, with physical abuse meted out by older boys under the guise of "punishment" for some minor misdemeanour or even under a false pretext. One applicant spoke of older boys blaming the

younger children for their own misdemeanours and in this way justifying their abusive behaviour. Several described the fear they felt from seeing other children being beaten by staff and older boys, with one saying that witnessing other boys being beaten was "the very distressing norm". Witnessing sexual abuse was another cause of the fear and anxiety that many applicants recalled.

Personal Emotional Abuse

28 Some applicants referred to the use of verbal abuse as a dispiriting and hurtful experience and means of control. They spoke of name-calling, of being referred to solely by a number, of being told lies about their families – for example, one man had been told that his mother was dead and only found out years later that she was alive when he was in an establishment. They also spoke of family denigration and of being mocked and belittled publicly for bed-wetting.

29 One applicant recalled being told by a member of the care staff that:

> "when you are dying on your death bed, you will want a glass of water and there will be no one there to give it to you."

This statement has remained with him and still pains him when he recalls it. Another applicant, reflecting what others implied, said that he had been subject to verbal abuse by nuns, who were care staff, and by older boys to such an extent that he thought it was normal. He added that the nuns always made him – and the other children – look down when they were being spoken to and he blamed this for his life-long difficulty in looking at others "in the eye" and standing up for himself. He was convinced this has disadvantaged him in work and life more generally. As he saw it, he thinks he has always been regarded as "shifty" because of his reluctance to make eye contact. Comments made by others included:

> "I was not referred to by name, only a number, the number used to identify clothing."
>
> "I was referred to as a piss bag as I wet the bed."

30 Witnessing the humiliation of other children was another factor in the emotional abuse recounted by some of the men. Humiliation was mentioned a number of times in association with bed-wetting; applicants spoke of this from direct experience of humiliation and also from the perspective of witnessing others being denigrated for having wet or soiled their beds. One man said that he is still upset by witnessing the actions

of one of his teachers, a nun, when dealing with a little girl who had soiled her underwear. The girl was made to take off her soiled underwear in class and show it to the other children. A male applicant described the practice he said he experienced because of being a "bed-wetter". The practice involved both emotional and physical abuse, as was often the case in other accounts of abusive experiences. He told the Forum that bed-wetters were put in a cold bath and held down by two boys at the instruction of the nun in charge.

> "A third boy poured bucket after bucket of cold water down on top of you."

Exposure to Fearful Situations

31 An applicant said that he had seen a member of the care staff kicking a boy across the floor. He then witnessed the same member of staff beating up the boy's brother who went to assist him. The applicant remained terrified of this member of staff for the duration of his stay in the establishment. He believed the member of staff would have killed him if he knew he had witnessed some of his abuse of other residents. The men said that some staff – both religious and lay – used the threat of physical abuse as a main means of control and of keeping them subdued. An applicant reflected the views of others in saying:

> "It was always in your mind 'I'm going to get hit by a nun or class boys'. When a nun put boys into cold baths, after they were brought back from running away, I, along with the others, had to listen to screams from bathrooms. The nun was red in face from beating the boys and their cries were like sounds from a slaughter house."

Deprivation of Affection

32 Commonly, applicants referred to the lack of warmth and affection shown to them by most care staff. They contended that they had had to fight for survival and fend for themselves in circumstances where they might have received comfort and encouragement from the staff. Emotional abuse was said to be widespread and systemic in nature. With the exception of a reference to another older male resident as a source of emotional abuse, all the others mentioned in applicants' accounts of the emotional abuse they experienced were adults – care staff, female and members of a religious order.

Neglect

33 Nineteen applicants made 23 allegations of neglect in the care they had received in respect of diet, clothing, excessive work and education. They made:

- Fourteen reports of neglect relating to one establishment
- Seven reports of neglect relating to another establishment
- Two reports of neglect, one in each of two establishments.

Diet

34 Fifteen of the male applicants talked about their diet, all of them saying that the quantity of the food was inadequate and the quality of food was poor. Two of that group blamed the inadequate quantity of food, in part, on the lack of supervision of the children at mealtimes. This allowed the bullies to take more of the food and select the better food. An applicant spoke about his diet in some detail saying that:

> "I was often hungry. I ate from rubbish bins – apple peels etc. This was in wartime; we had very basic food, porridge and tea for breakfast, stew at lunch time but little meat, bread and dripping for supper, dripping called 'chuck'. Older boys might take the dripping from you."
>
> "Hunger was a passenger always. Porridge and toast for breakfast, bread and lard with cocoa drink for supper. Things improved when we began to get bruised fruit* from the market. Each child got an apple or an orange and dived in to get share of anything left over. There was a tuck shop in later years as rationing eased."

***Note:** The reference to bruised fruit, above, is related to an arrangement spoken about by a number of residents from the same establishment, in which bruised and damaged fruit was brought to the establishment from a local market.

Clothing

35 Inadequate clothing, including footwear, was mentioned by four applicants as another form of neglect and criticism was levelled at both the quality and fitting of the clothes and shoes. Applicants said that they were frequently uncomfortable because clothes and shoes were too small. Two of them added that they felt inadequately dressed for cold weather and for playing outdoors. One complained about the lack of pyjamas saying that "we had to sleep in our underpants" and another said that he only got socks to wear when he was being taken out of the establishment.

Other Forms of Neglect

36 Other forms of neglect mentioned by more than two applicants included inadequate bedding, medical attention and education. Comments about these included:

> "The counterpanes and pillows were kept at the end of the big dorm. We slept with one sheet and one blanket. We were cold."

> "I was wounded badly on the knee having been hit with a stair spindle by a nun. My knee was patched up in the home; it was fractured and never set properly. It was tightly bandaged, but I was made to kneel on it in church even when very painful."

> "The home neglected my need for spectacles; this caused me difficulty in reading and in making progress in school."

> "Very little was taught in school. Catechism was the main topic."

Excessive Work Demands

37 Nineteen of the male applicants said they were given work that was both heavy and excessive for children. Of the nineteen, the majority – sixteen – described work that involved scrubbing, polishing and buffing floors in long corridors and other floors. Others were sent to work on farms and some mentioned having to care for toddlers, preparing food in the kitchen and cleaning bathrooms and toilets. The following quotations are typical of the accounts given to the Forum:

> "We had to scrub floors and polish them – up in the morning, supervised by class boys with pads right to left; washroom then to chapel and then breakfast."

> "We had a regime of polishing floors and, when older, helping in the kitchen. I also had daily duties on a different floor where elderly men were cared for. I had to empty the spittoons and the chamber pots. I also had to wash and shave the body of an old man who had died. I found this very distressing."

> "My chores included floor cleaning in the chapel, dining rooms, study halls, kitchen and lavatories. The buckets of hot soapy water were very heavy and I always had sore knees. After washing I had to polish the floors; I also had to clean the toilets and if any excrement was found by the nun inspecting our work, the whole team had to start all over again."

> "Work was constant from admission: washing, polishing floors – corridor a hundred yards long – dormitories and refectory. I had to look after babies and toddlers, prepare food and cook in the kitchen, do gardening, clean the school room, bathroom and toilets."

Knowledge of Abuse

38 Male applicants said that other residents and staff – care, ancillary and teaching staff – witnessed much of the abuse that was a common feature of their experience in their establishments. They also said that staff saw them crying and distressed and would have been able to see bruises on their arms and legs but rarely were they asked what was upsetting them or about what had caused their bruises. Those who absconded and were bought back to their establishments by the police often questioned why they were never asked about what was making them abscond.

Disclosing Abuse at the Time

39 Two of the male applicants who had been resident in voluntary establishments said that they had reported their abuse to adults. Others who had not reported commented that other children in the homes witnessed the abuse but were powerless to do anything about it. A number of them added that reporting abuse most often provoked one of three responses: disbelief, punishment or dismissal. The applicants insisted that there was little incentive to report their abuse; as one said "you soon learned there was no point in telling" and others reflected that they thought what they were experiencing was normal, "just part of life".

40 In one instance there was a positive outcome from reporting to an adult who was not a member of staff, in that the applicant who reported the abuse was moved to foster care. In another case the applicant told the Forum:

> "I tried to tell my mother on her yearly visits but I did not want to tell her full details and knew she could do nothing as she had to earn a living."

In describing his disclosure of his abuse to his family in later life, one man said:

> "I saw no point in telling anyone in the home as I thought I would not be believed and could suffer further physical punishment."

Methods of Coping with Abuse

41 The Forum asked the male applicants about how they had coped with or responded to the experiences they had described. Five responses to the alleged abuse were mentioned more often than any other and they were:

- not knowing what to do
- accepting the abuse as normal
- living in fear
- enuresis
- withdrawing into themselves.

The table below indicates the number of times these and other responses were mentioned by applicants in meetings with the Forum.

Responses to Abuse	Voluntary
Male	
Didn't know what to do	12
Self harm	-
Accept as normal	14
Fear	8
Enuresis	5
Withdrawal	5
Attack abuser	2
Run away	1
Retaliation	-
Alcohol abuse	-
Prescribed medication	-
Other	1

Note: Some applicants mentioned one or more responses; others mentioned none.

42 The selection of quotations that follows gives an insight into the thoughts and actions of some of the applicants in coping with their abuse.

> "My mother visited me and gave me new clothes which I put on my bed but someone cut them up with a razor blade. I didn't report this as I had been threatened that if I did complain I would be sent to a training

school for bad boys with the terrible threat of the…(the religious order in charge)".

"I considered the class boys as victims themselves as they would be punished if they didn't do as they were told. So I simply accepted abuse as normal. When I left the home I was very aggressive and this was a disadvantage as I was always getting into fights. In the army I often lost the opportunity to advance in rank as a result."

"Emotional, physical and peer sexual abuse were so commonplace that I did not appreciate that it was wrong in every way."

"I lost respect for authority and became fiercely independent in spirit."

"Later in life I just put it out of my mind and joked my way through life; if I dwell on it now it puts me back."

Strategies of Alleged Abusers

43 Three quarters of the applicants commented on factors that affected their response to their abuse and referred to the strategies used by alleged abusers. Most of their comments can be grouped into five broad categories, namely:

- the experience of being dominated by the authority of an older person, usually a manager or care worker
- violence on the part of the alleged abuser
- general fear – not knowing what might happen if they resisted or spoke out
- being told 'not to tell'
- bullying.

44 The quotations that follow give an insight into the circumstances and factors that inhibited the applicants' resisting and reporting their abusers.

"There was nowhere else to go – I didn't know any other world; everything we did we had to either ask or were told to do. There was no free will – we just obeyed."

"I was not known by my first name or surname but instead by my number which was…I remember seeing boys being beaten and I too was beaten so I always had to be hyper vigilant."

"I didn't know for a long time that my brothers were in the home (the same establishment) and my sisters were in another home close by. Relationships with my brothers and sisters were denied to me."

"Older boys often were in charge without supervision and we couldn't disobey them."

"An older boy made me perform oral sex on him to avoid being given a cold bath and a beating for bed-wetting. This boy had the job to get the bed-wetters up at night to prevent wet beds."

"When I was thirteen or fourteen, I was told my mother had come to see me. I had never heard of my mother. The nun told me to say 'It's nice here, I love it here, it's a great place to be' and to give her a big hug. I didn't report my abuse as I was threatened that if I did I would be sent to...a place for bad boys. I cried every night for two years because I was so unhappy in..."

"I was constantly threatened with 'if you don't behave, you will be sent to live with your mother.' I never got an explanation of why this deterrent was used but I knew that it was frightening. I was labelled a 'retard' and denigrated and physically reprimanded as I was a bed wetter."

"There was a culture of punishment in...and I lived in the shadow of that. The punishment was administered by older boys and by nuns."

"I was not referred to by name; I didn't know about or celebrate birthdays; the use of each others' names was forbidden. Before we went on a walk we were warned not to smile, nod, wave or talk. I never saw a toy. I always had to look down and never to speak before being asked a question. There was no mammy's knee. My childhood was gone – I never had a childhood."

Females: Voluntary Provision

45 Twenty of the female applicants, who were resident in voluntary establishments from 1922 to 1955, referred to having experienced abuse. Some referred to more than one form of abuse and by more than one perpetrator. The combination of abuse types in different placements mentioned by applicants is shown below. It is important to emphasise that the table does not indicate the number or frequency of individual incidents of abuse but, rather, the total number of times particular types of abuse were mentioned by the twenty female applicants in their meetings with the Forum.

Abuse types	Applicants	Establishments
Physical, sexual, emotional and neglect	2	2
Physical, emotional and neglect	12	5
Physical, sexual, and emotional	-	-
Physical, sexual and neglect	-	-
Physical and neglect	-	-
Physical and emotional	1	1
Physical and sexual	-	-
Emotional and neglect	1	1
Emotional and sexual	-	-
Emotional, sexual and neglect	1	1
Emotional	1	1
Sexual	-	-
Physical	1	1
Neglect	1	1
Total	**20**	*

***Note:** 6 **different** establishments in total

Physical Abuse

46 Sixteen of the female applicants who had been cared for in voluntary establishments made 21 reports of physical abuse. They spoke of treatment that they considered to be physically abusive in six different establishments. There were:

- Twelve reports of physical abuse in one establishment
- Six reports of physical abuse in another establishment
- Three reports of physical abuse, one in each of three establishments.

Descriptions of Physical Abuse

47 Most commonly the applicants referred to being beaten with a strap and a cane, usually on the hands and legs and, in some of the more severe beatings they described, all over their bodies and especially where bruises would not be seen. They said that these punishments were given for even minor misbehaviours, and mentioned "talking back" to a member of the religious care staff, doing something the wrong way or simply being

mischievous as some of the triggers for physical punishments. One told the Forum that she experienced beatings "over and over again because nothing I ever did was good enough." Another applicant was very emotional and found it hard to talk about the beatings she had received. She said she has felt ashamed all her life of being beaten as a child, so much so that she continues to have great difficulty in referring openly to this part of her childhood experience. Yet another woman described being placed in a room with her younger sister and then being wakened during the night by a nun who was a member of the care staff. She and her sister were told to get out of their beds by the nun who then poured cold water onto their sheets and told them to get back into bed. She reported that the nun returned later and beat them for wetting the bed. Another woman told the Forum:

> "You would be hit if you talked back or didn't do something right. You got hit all over the body where you couldn't see it."

Physical Abuse by more than one Person

48 A number of the applicants alleged physical abuse by more than one person. In summary, the Forum heard:

- Five reports of abuse by one person
- Five reports of abuse by two persons, either separately or concurrently
- Two reports of abuse by three persons, either separately or concurrently.

The alleged abusers, with two exceptions, were female; their roles are set out in the following table.

Roles of Alleged Abusers	Male	Female
Officer in charge/authority figure	1	5
Care staff	-	7
Teacher/instructor	-	3
Former resident	-	-
Other resident	-	1
Visitor	1	-
Ancillary worker	-	1
Total	**2**	**17**

Of the nineteen alleged abusers, fifteen were members of a religious order and one was a parish priest.

Sexual Abuse

49 Three of the female applicants who had been placed in voluntary establishments reported sexual abuse. These applicants had been in two separate establishments. One of them told the Forum about a female member of staff digitally penetrating her after she was given a cold bath (being bathed in cold water was described as routine). She made no other allegations of sexual abuse.

50 Another applicant spoke about being fondled inappropriately by a male teacher in her establishment and also reported witnessing similar abuse of another child in the same establishment. She alleged that a teacher "felt up the girls' legs in class." She pushed him away when he tried to do this to her. She said she saw another male member of staff fondling the breasts of a girl as she played the piano.

Emotional Abuse

51 Eighteen female applicants who had been placed in voluntary establishments reported emotionally abusive experiences. There were:

- Eleven reports of emotional abuse in respect of one establishment
- Two reports of emotional abuse in respect of two establishments
- Three reports of emotional abuse, one each in respect of four establishments.

These female applicants referred to emotional abuse types that were similar in range and intensity to those of the men.

Personal Emotional Abuse

52 The applicants recalled living in fear of physical abuse and of experiencing verbal abuse including constant personal denigration; one spoke of being called by a number rather than her name. One talked emotionally about being told she was a demon, of being "worthless and evil" and of being publically humiliated. Another applicant said:

> "I was repeatedly told that I would not amount to anything and that I would end up in the gutter". Comments from others included:
>
> "I was blamed for things I didn't do such as stealing, and a notice saying 'Thief' was pinned to my back. On another occasion my pony tail was cut off as a punishment. These and other events humiliated and affected me negatively."

"I was made to sit at a table away from the other children as I was Protestant – I was made to feel inferior and different."

"I experienced public humiliation: I was made to stand in the corner in school and wear a hat with 'dunce' or 'thief' on it. I stole apples at every opportunity to try and feed my sisters and friends. I was shown no affection by anyone there."

"I suffered from chronic enuresis. At school (on-site) I was not allowed to go to the toilet except at designated times. On one occasion I wet the floor and had to go through a number of classrooms to get a mop and bucket. Everyone knew what I had done."

"The children who wet the bed were not allowed to get into their beds until after the non bed-wetters. I recall one time when I was made to stand in a cold, dark corridor for so long that I fell asleep upright."

"As children we were not allowed to leave the table until we had finished everything on our plates. On one occasion, I had nothing but a large piece of fat left and couldn't eat it. I was made to sit until it was dark trying to eat the food when a woman from the kitchen that I remember as being kind, told me to get to bed."

Family Denigration and/or Links Discouraged

53 A number of the women expressed regret that they had been separated from their siblings, including some who had sisters in the same establishment and some who had brothers in an adjacent establishment. They said that there was no encouragement of sibling relationships and several said they were deliberately kept apart from their siblings even though they kept asking about them and making it clear that they wanted to see them. One woman, for example, said that she and two younger sisters were placed in the same establishment. When admitted, she was seven years old and her sisters were five and three years old respectively. She said that they were split up and not allowed to see each other at any time.

Other applicants reported:

"I never knew my sister who was in the same institution – we went in together but I was only two years old and so lost my memory of her. When we met to receive a visit from our father we were left sitting in the parlour together but not introduced. I had no concept of what 'sister' meant."

"I discovered in later life that my only brother was working near the establishment and I was not even told he existed."

"I was not permitted to have a relationship with my sisters who were also resident in the home."

"I regret that I was not given the opportunity to get to know my sister. We were kept apart."

Exposure to Fearful Situations

54 An applicant described graphically an occasion when a child died in her establishment. She said that the girls were made to walk round the dead child's bed and, when they asked what had happened to her, a member of staff told them that "she was possessed by the devil."

55 Repeatedly applicants spoke of the distress they experienced when witnessing other children being admonished and beaten by care staff. They indicated that they lived in fear of the same treatment. One applicant reported witnessing peers being subjected to physical abuse. She recounted that three girls ran away and when they returned all the children were summoned to the refectory and were made to watch as three nuns cut their hair short. She was very upset when she recalled the girls crying as they watched this humiliating event.

Deprivation of Affection

56 A recurring theme in the accounts given to the Forum was the lack of affection and warmth in the care received. The comments of one woman reflect the sentiments of many: "I have no positive memories of being nurtured". Other comments included:

"No one showed me any affection. The best time I had was in hospital with sepsis from a splinter in my foot. The staff there were lovely."

"No kindness was shown to me; I believe I was singled out for particularly harsh treatment as I was born outside marriage."

Neglect

57 Seventeen female applicants complained of neglect:

- Sixteen applicants reported one instance of neglect
- One applicant reported two instances of neglect.

58 The number of complaints in respect of the six voluntary establishments was as follows:

- One establishment was the subject of twelve complaints of neglect
- Five establishments were each the subject of one report of neglect.

Diet

59 Fourteen of the women who had been placed in voluntary children's homes made reference to aspects of their care that they considered to be neglectful. Ten applicants said that their food was not only poor in quality but was also inadequate in quantity. Typical comments made to the Forum included:

> "I was hungry all the time."
>
> "I would pinch food all the time, including slops from the bins."
>
> "Bread and dripping with one cup of tea for breakfast, fatty meat for dinner and we were made to eat any food we vomited."
>
> "I used to climb out at night to rob apples as I was so hungry."
>
> "I was always hungry. There was never enough food and what was provided lacked nutrition and was horrid – lumpy, salty, cold porridge."
>
> "We were given one sausage on Christmas Day and an egg at Easter."
>
> "I ate from the slop bucket. I ate turnip skins and I stole apples as often as I could."
>
> "I was hungry all the time when I was younger. Meals were served in a refectory at long tables. The food was placed in the middle of a table and there was a free-for-all. As I was sitting at the end of the table and I was smaller, I never got enough to eat and I would go later to the bins and scavenge for leftovers and peelings."

Excessive Work Demands

60 Six of the women referred to inappropriate and excessive work demands as factors in their neglect. One said that "We worked from 7.00am to 8.00am every morning, polishing floors etc"; she added that the worst job was manually unblocking toilets with bare hands. Another told the Forum that

> "We were like slaves doing their work for them, scrubbing and polishing floors until you could see your face in the shine."

A third applicant reported that work was constant from admission:

> "every Friday night five pairs of girls were on their knees scrubbing corridors and the chapel. I never saw a nun do physical work."

This applicant had special duties looking after an older girl who appears to have had learning difficulties; she said she was completely responsible for her. She added that she was also in charge of the top bathroom which had about eight sinks, as well as toilets and baths. She had to ensure it

was clean every day from getting-up time. She was about eight or nine years old at the time. When she was older, she also worked in the kitchen, the laundry and the adjacent residential home for older people.

Inadequate Medical Care

61 Some of the women spoke about the inadequacy of their medical care. One commented on her care when she became seriously ill and received medical attention for some time. Her aunt came to visit her and a row ensued with the care staff because she was so shocked by the condition of her niece who was emaciated and barely able to walk. Another recounted having an outbreak of boils on her neck, underarms and knees. These were not treated and she recalled that when she was unable to bend both knees to pray, a nun pushed her down and said "we pray to God on both knees." She added:

> "I was in great pain and my sister who had witnessed this ran over to help me."

Lack of Opportunities for Play

62 Several of the women complained about the lack of play opportunities, toys and books. One applicant's account was as follows:

> "No toys were provided and those in the garden were not adequate for the numbers of residents. Toys were produced for inspections and for a TV company filming in the garden but they were then removed immediately afterwards – I was astounded that the visitors didn't notice the children's reaction to seeing the toys or that they were new."

Knowledge of Abuse

63 The applicants' accounts of their physical and emotional abuse and neglect make it clear that there must have been many witnesses to what they experienced. Not only were other residents present in most instances but so too were other members of the care staff and ancillary staff. However, few of the applicants made reference to this. One applicant asked "Why did no one do anything to stop what was going on?"

Disclosing at the Time

64 One of the 24 female applicants who had been in designated voluntary establishments said that she had reported her abuse just after it had occurred and that, at least initially, her action had results. She said:

> "I showed the priest, who was supportive of the children, the welts on my legs caused by a nun. He told the nun to get him the cane. She did and he admonished her and said he never wanted to see marks like that on legs again. After he left, the nun used her knuckles on my head and then, after a while, reverted to using the cane."

None of the others had reported their abuse and told the Forum that the threat of physical punishment silenced most children, coupled with the ongoing verbal admonishment from angry adults.

Methods of Coping with Abuse

65 The Forum asked the female applicants how they had coped with the experiences they had described. Five responses to the alleged abuse were mentioned more often than any others and they were:

- not knowing what to do
- accepting the abuse as normal
- fear
- enuresis
- withdrawing into themselves.

The table below indicates the number of times these and other responses were mentioned in meetings with the Forum.

Responses to Abuse	Voluntary
Females	
Didn't know what to do	5
Self harm	-
Accept as normal	7
Fear	3
Enuresis	2
Withdrawal	6
Attack abuser	2
Run away	2
Retaliation	1
Alcohol abuse	-
Prescribed medication	-
Other	-

Note: Some applicants mentioned one or more methods of coping; others mentioned none.

66 The selection of quotations that follows gives an insight into the thoughts and actions of some of the applicants in regard to coping with the abuse.

"I didn't accept the abuse; I constantly rebelled against it – I would not go to Confession. I continued to assert myself and tried to help others."

"I answered back, something nuns didn't like."

"I ran away twice but I was found by police and brought back. They (the staff) put me in a dark cupboard for a few hours with no food. When the police came to see me the next day I told them I was hungry but they didn't take any notice and I was punished again."

"At times I felt that this was my lot. I had no choice but to accept the treatment."

"I put it to the back of my mind; I could have committed suicide, instead I dealt with it by forgetting it."

"I had no family and been brought up in an institution. I had no resources to rely on."

"I wouldn't dare complain to the doctor as the nun who was present would later on give you a hiding for telling the doctor something and not telling the staff first."

"I was continuously frightened. If you looked the wrong way you were told 'sit down, behave, I don't want to hear from you, you should know your place.'"

"I lived in an environment that evoked fear; it was dark and suffocating."

"The police took us back every time; they never asked us why we were running away."

"When I was wrongly accused of stealing, I resolved not to help the nuns again."

Strategies used by Alleged Abusers

67 Almost all of the female applicants who had been placed as children in voluntary establishments prior to 1956 commented on factors that inhibited them in speaking out about their and others' abuse. Most of their comments can be grouped into five broad categories, namely:

- the influence of the authority of an older person, usually a manager or care worker
- violence on the part of the alleged abuser

- general fear – not knowing what might happen if they resisted or spoke out
- being told "not to tell"
- bullying.

68 The comments that follow give an insight into the distress felt by the applicants when they were children and help to explain why they were so reluctant to report abuse.

> "We were beaten regularly. One incident I remember as follows: someone scraped a hole in the wall in the WC, we were all made to line up as a nun walked up and down the line. She stopped at whoever she decided was the guilty party. The girl was lifted off her feet by her hair, beaten badly by stick and thrown into an under-stairs cubbyhole with a small window. When this happened to anyone, the nun made noises outside to scare you, and hours after the other children were in bed you were dragged upstairs to the dormitory."

> "Decisions were taken about me and nothing was explained – care staff gave no sense of appreciating the use of explanation to alleviate fears or to be inclusive."

> "I was threatened with being sent to…by one of the nuns. I knew of it as a place for mad people and another girl had gone there. The threat made me very frightened."

> "I was not chosen for outings or activities like choir. My hair was washed in public, in the back yard, overlooked by boys who taunted us. I suffered from nightly enuresis, and we were called 'wet the beds'. Once you wet the bed at night you had to remain in your wet sheets, and next morning you had to wash the sheets in cold water. Later buzzers were introduced, but other children were wakened by the buzzer going off and I, with others, was verbally abused by the other children."

> "I was made to line up with my underwear inside out; I was hit on the face if my underwear was marked. I was told publicly I was backward."

Abuse in State Provision

69 This section refers to the abuse reported to the Forum by those applicants who were resident in state provision between 1922 and 1955. Six male applicants and one female applicant were in that category.

Males: State Provision

70 Of the six males in state establishments in this Period three did not have any abuse to report. In one applicant's case the abuse he suffered took place in an establishment during Period 2. Another was in a state establishment only briefly where, he said, he was cared for appropriately before being placed in a voluntary establishment where he alleges he was abused. A third, although in a state establishment in Period 1, spoke of abuse he experienced in a foster family setting to which he was sent from the state establishment. That abuse is outside the terms of reference of the Inquiry.

71 The combinations of abuse experienced by the other three men in three separate establishments were as follows:

- One man reported experiencing physical, sexual and emotional abuse and neglect
- One man reported physical abuse
- One man reported sexual abuse.

Physical Abuse

72 None of the six men who had been in state establishments reported any physical abuse by care staff. The two who alleged physical abuse said that this came from other residents. One recalled an incident in which he had been hit on the head with a bottle when he refused the older resident's request to go to his 'den'. The applicant said that he knew he would be abused if he complied. He was taken to a doctor for attention to his injury.

Sexual Abuse

73 Two of the six male applicants who had been placed in state establishments spoke about sexual abuse. One of the two, who had lived in a state workhouse with his mother and brother, reported that he was anally raped by an older resident and that he was the focus of genital exposure by a group of older residents who tried to involve him in sexual activities.

74 The other applicant recalled that he was sexually abused, "interfered with and raped" by several men who worked in his establishment. He said that this happened frequently: "it was going on all the time". One of the men would sexually interfere with him in the boiler room. He would threaten that if he would not comply he would put him in the boiler.

Emotional Abuse

75 Two of the six men who had been cared for in state establishments made references to emotional abuse but did not detail the nature of the experiences that affected them in that way.

Neglect

76 None of the six male applicants who had been in state children's homes alleged neglect.

Alleged Abusers

77 The alleged abusers referred to by male applicants were either other residents or staff who worked in management and care. The following table summarises this information:

Roles of Alleged Abusers	Males
Authority figure/officer in charge	2
Care staff	2
Ancillary	-
Teacher	-
Visiting adult	-
Other resident	2

Disclosing abuse at the Time

78 The two applicants who alleged sexual abuse in state establishments told the Forum that they had reported the abuse but to no effect. One said that:

> "I feel my action was dismissed; the staff member I told said 'away you go'. It seems that sexual abuse was part of the culture of the institution."

The other told the Forum that:

> "(after a sexual assault) I was cleaned up by another resident whose assigned duties included supervising toilets. This man reported it to the officer in charge who gave me to understand I needed to be careful about going into toilets if the supervisor was not there. I felt he was saying I was to blame."

How compliance was achieved: Strategies used by Alleged Abusers

79 The abusers in one establishment were in positions of authority and threatened one applicant with dire consequences if he told anyone what

they were doing to him. In the other case, the applicant was intimidated by older residents, in effect adults around twenty years of age.

Methods of Coping

80 The Forum asked the applicants about how they had coped with or responded to the experiences they had recounted. Three ways of responding to the alleged abuse were mentioned and they were:

- not knowing what to do and so doing nothing
- accepting the abuse as normal
- being frightened.

Females: State Provision

81 One female applicant came to the Forum to recount her childhood experiences in state care. She had one complaint and that focused on physical abuse and bullying by other residents.

Male: Juvenile Justice Provision

82 This section refers to the abuse reported to the Forum by the two applicants, both males, who had been in juvenile justice establishments between 1922 and 1955. The applicants had been in the same establishment but at different times. They spoke of the following types of abuse.

Physical Abuse

83 One of the applicants complained of physical abuse that was extreme and ongoing, saying that he was beaten with a leather strap by religious staff and bullied and beaten by other, older, residents. The other applicant complained of being strapped and beaten by staff who were also members of a religious order.

Other Abuse

84 Neither of the applicants reported sexual abuse; one referred to emotional abuse without giving examples.

Knowledge of the Abuse at the Time

85 Neither of the applicants referred to having reported their abuse but they told the Forum that the abuse happened in the presence of other staff and residents.

Closing Comment

86 The applicants who had been in children's residential establishments between 1922 and 1955 said that their anger about the abuse they had experienced had not diminished over the years. Their sense of injustice at not being believed and their frustration from being ignored and dismissed when they reported abuse has increased over time. They acknowledged that some staff had been good to them but others had treated them cruelly and exploited them and they wanted this to be "on the record".

Period 2: 1956-1975

Introduction

87 This section of the chapter sets out the abuse that 125 male and 85 female applicants allege occurred when they were placed in the care of 35 establishments in Northern Ireland from 1956 to 1975. The section is divided into three: abuse alleged in voluntary establishments, abuse alleged in state establishments and abuse alleged to have occurred in juvenile justice establishments. Each part of this section describes the experiences of the male and female applicants separately.

Voluntary Establishments

88 The first part of this section covers the experiences of 75 male applicants who spoke of abuse in nine voluntary establishments. Two applicants did not report any abuse in their placements in voluntary establishments. The second part of this section covers the experiences of 74 females who spoke of abuse in twenty establishments in the voluntary sector.

89 Some applicants alleged experiencing one type of abuse from more than one alleged perpetrator. For example, they may have alleged physical abuse by two or three perpetrators and may also have reported emotional abuse by one of those staff members or by another staff member.

Males: Voluntary Provision

90 The 75 male applicants spoke of abuse in nine establishments. Most of the abuse that was reported to the Forum was alleged to have occurred in three establishments, two of which were the focus of complaints of abuse from 28 applicants. The third establishment, was the focus of complaints

from 23 applicants. The table that follows sets out the combinations of types of abuse alleged by the 75 male applicants.

Abuse types	Males	Establishments
Physical, emotional, neglect and sexual	28	4
Physical, emotional and neglect	16	6
Physical, emotional and sexual	12	4
Physical, sexual and neglect	1	2
Physical and neglect	1	1
Physical and emotional	4	3
Physical and sexual	4	3
Emotional and sexual	2	1
Emotional, neglect and sexual	2	2
Emotional only	-	-
Sexual only	3	1
Physical only	2	2
Neglect only	-	-
Total	**75**	**29***

* **Note:** Nine establishments were reported by different applicants for different types of abuse.

Twenty-eight applicants reported experiencing all four types of abuse. Sixteen applicants reported experiencing physical abuse, emotional abuse and neglect.

Physical Abuse

91 Sixty-eight applicants made, in total, 149 complaints of physical abuse in respect of nine individual voluntary establishments. These 68 applicants had a total of 88 placements. The following table sets out the extent of reports of physical abuse per establishment.

Individual Placements	Establishments	Reports
28	1	67
28	1	38
23	1	29
3	1	3
2	1	3
1	1	3
1	1	2
1	1	3
1	1	1
Total - 88	**9**	**149**

Descriptions of Physical Abuse

92 Male applicants who had had placements in voluntary establishments alleged being physically reprimanded by some members of staff who, as a standard control mechanism, would punch, slap and kick them. Some applicants described the physical abuse they were subjected to as persistent and routine. Applicants alleged that staff used the following items to physically reprimand them: leather straps, a blackthorn stick, canes, keys, brooms, bats, a kettle flex, a wooden towel rail, tennis rackets, a chair leg, a golf club and a hurling stick.

93 There were accounts that physical abuse could be given for a minor misdemeanour or, at times, applicants commented: "We just happened to be in the way of the member of staff." Some of the applicants said that, from time to time, some of the staff appeared to lose control and the punishment was disproportionate to the misdemeanour. One applicant alleged getting beaten by a member of staff and receiving "man-sized punches." Some applicants said certain members of staff instructed them to sleep with blankets over their heads or lie with their arms folded across their chests. If they failed to comply, they would be beaten by either older boys or some of the staff. One applicant referred to one particular member of staff who lifted the boys off the ground by the cheeks or the ears and, on occasion, threw them against a wall.

94 Some applicants who spoke about constant physical abuse in their placements described experiences that included being beaten, waiting for a beating or watching another resident being beaten. One applicant recounted that "fear was put into you from day one." Another applicant stated, "I have lost count of how many times I was hit." Another applicant

described a particular incident when he was repeatedly beaten by a member of staff who "showed no mercy."

95 Some applicants recounted that some of the nuns had favourites amongst the children, who then were known as the "pets or dainties." One of the applicants said that, through having this status, he received extra portions of food and was selected to go on outings. A few applicants commented that these children received preferential treatment because their mothers were paying for their keep in the establishments.

96 Some of the applicants felt they were singled out for harsher treatment than their peers and this was puzzling and particularly upsetting for them at the time. In hindsight, they correlate this with their personal circumstances, such as the mother being a single parent, having parents who were unmarried, their families not contributing financially to the cost of care in the home or, coming from a different religious background. There were also accounts in which specific staff were said to pick on certain children. One applicant recounted that he desperately wanted to pass the 11-plus only to learn that he had failed. A staff member announced this in front of everyone in his group in the establishment:

"We have a stupid person among us who thought he was clever."

This applicant said that the memory of this still remains painful for him and he fails to understand how someone could behave in such an inappropriate way towards children.

97 Applicants who had a history of enuresis alleged being publicly humiliated and physically harmed because of their condition. One applicant recounted that as a bed wetter, he was awakened during the night to go to the bathroom by staff hitting him. One applicant alleged a member of staff repeatedly hit him but he refused to cry. He said the physical abuse became more persistent and extreme and when he did eventually cry, the beatings ceased. This applicant commented, "I was beaten until I broke." One applicant recounted being beaten with a rod of wire "like a TV aerial" which was used to "prod the boys…like hitting cattle."

98 Applicants made the following comments when recounting their experiences of abuse in voluntary establishments:

"If you fought back you never won."

"A staff member was determined to break me."

"I was being beaten left, right and centre."

"I have lost count how many times I got hit."

"You got so used to it, it didn't affect you anymore."

Physical Abuse by more than one Person

99 Many applicants reported to the Forum that they were physically abused by more than one person. The following is a summary of the information they provided:

- One applicant alleged physical abuse by seven people.
- Three applicants alleged physical abuse by six people.
- Three applicants alleged physical abuse by five people.
- Five applicants alleged physical abuse by four people.
- Ten applicants alleged physical abuse by three people.
- Twenty-five applicants alleged physical abuse by two people.
- The remaining 21 applicants alleged physical abuse by one person.

Note: The allegations of abuse may have involved two or more people concurrently.

Role of Alleged Abusers

100 The table that follows shows the position within the institution of the alleged abusers as understood by the applicants. Some applicants could not provide any information on the name or position of their alleged abuser. Other residents were sometimes noted as bullies by applicants, but not usually identified by name and therefore are not included in the table below. It was not possible to ascertain how many residents were alleged to be physically abusive.

Role of alleged abuser	Males	Females	Member of Religious Order/Clergy
Officer in charge/ authority figure	51	29	60
Teacher/instructor	18	4	11
Care staff	45	23	47
Ancillary staff	8	3	2
Other (role not clear)	3	-	-
Total	**125**	**59**	**120**

Physical Abuse by Older Boys

101 Eight of the applicants recounted being subjected to physical abuse by older residents who had been given charge of them. The applicants described staff authorising the older boys to keep control and order. The result was that the younger children were left unsupervised and the older residents displayed aggressive behaviour towards them. Applicants recounted the fear they felt as the older boys would beat, slap and kick them and they were afraid to tell of the abuse for fear of being beaten. Some applicants said that they reported the abuse to staff but they were not believed, or that their reports were dismissed and they were not offered any support.

Sexual Abuse

102 Fifty-two male applicants made, in total, 104 reports of sexual abuse in five individual establishments in the voluntary sector. Twenty-eight of them referred to sexual abuse only once but it was clear that for some of them the abuse had been ongoing. The other 24 referred to two or more instances of sexual abuse, with one applicant reporting ten instances in what had been a prolonged experience of sexual abuse.

103 Forty-nine applicants reported sexual abuse in combination with other types of abuse, while three applicants reported sexual abuse only.

- One establishment was the subject of sexual abuse reports by 31 applicants.
- One establishment was the subject of sexual abuse reports by sixteen applicants.
- One establishment was the subject of a sexual abuse reports by nine applicants.
- One establishment was the subject of sexual abuse reports by four applicants.
- One establishment was the subject of sexual abuse report by one applicant.

Some of the 52 applicants had more than one placement and reported sexual abuse in respect of more than one establishment.

The Nature and Extent of Sexual Abuse

104 The complaints reported by applicants refer to allegations of sexual abuse perpetrated by residential and non-residential staff, older residents, former residents and visitors. The alleged sexual abuse was said to have

taken place in various locations including inside the establishments, in the grounds of the establishments, and in various holiday homes during the summer holiday period. The full range of types and numbers of reports of sexual abuse are set out in the following table.

Types of sexual abuse	Number of reports
Inappropriate fondling	18
Anal rape	14
Oral/genital contact	11
Masturbation of child	9
Masturbation of alleged abuser	14
Indecent exposure	6
Coercive peer abuse	16
Witnessing sexual abuse	7
Use of violence	4
Grooming	5
Total	**104**

105 Some of the applicants referred to a culture of ongoing sexual abuse within their establishments and many found it particularly difficult to talk about the sexual abuse. Some of the applicants commented that in later life they had felt unable to talk of their experiences of abuse as they were concerned they would be stigmatised or judged negatively. Some of the applicants said they felt ashamed and this had kept them silent over many years.

106 An applicant who described himself as a "pet" of a particular member of staff said he received privileges from this staff member who continued to sexually abuse him. Another applicant alleged the boys would be given "the odd pound and fags" by the older residents so that they could abuse them. An applicant said that the showers were allocated on a rotational basis and boys were called to the shower but the residents who were "liked" by certain staff members would be chosen more regularly and they were watched very closely. An applicant in a large establishment said that he and other residents were "like meat in a butcher's shop." This applicant spoke of a member of staff masturbating him whilst he lay in his sick bed.

Sexual Abuse by more than one Person

107 Many applicants reported to the Forum that they were sexually abused by more than one person as follows:

- One applicant reported that he was abused by ten different alleged perpetrators
- Two applicants reported they were each abused by six different alleged perpetrators
- Three applicants reported they were each abused by four different alleged perpetrators
- Three applicants reported they were each abused by three different alleged perpetrators
- Fourteen applicants reported they were each abused by two different alleged perpetrators.

The other 29 applicants reported that they had been abused by one alleged perpetrator.

Alleged Abusers

108 Four of the alleged perpetrators were reported to be female and the rest of the alleged perpetrators were male.

Role of the Alleged Abuser	Female	Male	Member of Religious Order/Clergy
Officer-in-charge/ authority figure	-	21	12
Care staff	2	29	26
Teachers/instructors	-	2	-
Ex residents	-	6	-
Other residents	2	31	-
Visitors	-	4	2
Ancillary workers	-	8	-
Totals	**4**	**101**	**40**

Emotional Abuse

109 This section of the report describes emotional abuse in voluntary establishments from 1956 to 1975. Emotional abuse covers a range of actions and inactions that deprived the applicants of family and sibling contact, knowledge of their own identity, affection, approval and protection from harm appropriate to their age and developmental needs.

In their descriptions of emotional abuse, applicants most often referred to practices and routines, for example, the separation of siblings and the removal of all personal belongings or the absence of individual, personal treatment. Emotional abuse as such was not often ascribed to individual staff but was generic and described as systemic in nature.

The Nature and Extent of Emotional Abuse

110 Sixty-four male applicants reported emotional abuse in combination with other types of abuse. None of them reported emotional abuse as the only form of abuse they experienced.

- One establishment was the subject of emotional abuse reports by 24 applicants
- One establishment was the subject of emotional abuse reports by 22 applicants
- One establishment was the subject of emotional abuse reports by 21 applicants
- One establishment was the subject of emotional abuse reports by two applicants
- Four establishments were each the subject of emotional abuse reports by one individual applicant.

Some of the male applicants had been placed in more than one establishment. Nine applicants made allegations of experiencing emotional abuse in more than one establishment.

111 The range of emotional abuse described in the eight establishments is set out in the table below.

Type of emotional abuse	Number of reports
Shown no affection	9
Public humiliation	14
Personal denigration	13
Removal of personal belongings	14
Family denigration	20
Family contact discouraged	18
Sibling links discouraged	12
Inappropriate exposure to fearful situations	30
Other	7
Total	**137**

Personal Emotional Abuse

112 Applicants who recounted emotional abuse spoke of living in fear, being ridiculed and belittled by staff and older residents and having to remain vigilant at certain times or at all times. Some applicants described a childhood characterised by fear and loneliness with the absence of emotional warmth and encouragement. One applicant said "no one cared for you…you were totally alone." Applicants spoke of feeling depersonalised with little or no recognition that they, as children, were individuals with feelings. There were descriptions of applicants being given a number and referred to by such, and not addressed by their given name.

113 Applicants provided accounts of being publicly humiliated, citing examples of those who were bed-wetters being ridiculed in the presence of their fellow residents. Some applicants recounted that they were so frightened of wetting the bed that they were afraid to fall asleep in case this would happen and they would have to face the consequences of being ridiculed and beaten in the morning.

Applicants alleged that staff in certain establishments inspected their underwear. One applicant recalled that when he was around twelve years of age, the boys had to stand in line and had to hold out their underpants for inspection. If the underwear was stained, they were publically berated and at times beaten by staff. One applicant alleged that if one boy's underwear was stained, all the boys were punished by having their pocket money docked, adding "the shame of having to do this was worse than the beatings." One applicant recalled an instance when a boy soiled himself and a member of staff rubbed the soiled underwear in his face; the applicant commented that this was "barbaric."

114 There were accounts of staff making inappropriate comments to children and derogatory name calling, such as "scar face", "stupid", "space boy" and "rabbit teeth." One applicant recounted some members of staff mocking him due to his speech impediment. Another applicant was referred to as a "mongrel" as his parents were from a mixed religious background. One applicant recounted that he was commonly addressed by staff as a "rotten egg…from the backstreets of Belfast." Several applicants alleged that they were called a "dirty bastard" and others were told they were in care because "no one wanted you." One applicant recounted watching a staff member approach another resident and coldly tell him his mother had died and then just walk away from the boy.

115 Three applicants who had been in the same large establishment reported that the boys who wet the bed were made to sleep in the 'wet house'. This was in the grounds, separate from the main house, and the boys had to run up to the main house in the morning holding their wet sheets while some of the older boys jeered at them.

Family Denigration and/or Links Discouraged

116 Some applicants said that contact with their birth families was not promoted or supported and that this caused them great regret and sadness. One applicant who was discharged in the 1960s recounted that: "my parents were treated like dirt" when they came to visit and were received very differently to the "upper class visitors who would come to take children out". The visitors would be taken into "nice rooms with toys in them" but his mother was made to wait in a cold corridor.

117 One applicant told the Forum that his grandparents, to whom he was very attached, regularly made the long journey to see him in the establishment. He described staff ridiculing and sneering at them, calling them inappropriate names and refusing to allow them to enter the premises. Immediately after his grandparents left, staff would throw the food they had brought him into the bin.

118 Several applicants said that they were not informed that they had siblings in the same establishment. Applicants who did know their sibling(s), recounted that their important bond should have been promoted instead of being frustrated or obstructed. One applicant recounted that his little brother was in another part of the establishment and the only time they saw one another was when he got into trouble and was brought to the part of the building where the applicant was based. He reflected that he believed his little brother "deliberately got into trouble, just so he could see him."

119 One applicant spoke of an older sister travelling to see him. He referred to the lack of public transport at that time, and described her lengthy travel as a "camel's journey." On some occasions, she was refused entry by staff. If she was permitted to see him, it was for no more than ten to fifteen minutes. He felt that these actions were intended to punish him. One applicant alleged that he received a letter from his sister eight years after she had written it. Another applicant alleged that the letters he had written to his sisters were not posted to them.

120 Another applicant described the impact of his separation from his siblings when he was admitted into care. He recounted that he was initially placed with his brother, who was vulnerable and was suddenly moved to another placement without explanation as to why. They were given no opportunity to say goodbye to each other.

The following quotations are further examples of what applicants said about sibling contact:

> "I didn't know my brothers were resident in…at the same time."
>
> "My sisters were placed in another institution and although they attended the same Church every Sunday, I was not told they were my sisters."
>
> "I saw my younger sister in church and climbed over the pews to her and was later physically punished by a member of staff."
>
> "Some of my family were denied contact with me as they were of a different religious persuasion."

121 Some applicants also felt that they were prevented by staff from enquiring about or mentioning family members. One applicant, who had spent all of his childhood in care, plucked up the courage as a teenager to ask staff "can you tell me who my mother is?" and was promptly told "You don't need to know…we have done our best for you." This applicant commented

> "It is very hard not to know who your parents are – other boys found out and it helped them."

122 Some applicants told the Forum that the threat of ending contact with family members was often used by staff. One applicant, who had formed a strong attachment to his foster carer and referred to her as his "holiday mum", alleged that he was told constantly that he would not be allowed to go and stay with her if he was guilty of the slightest misdemeanour. He added that being with her was "the only happy time of my childhood".

123 An applicant who had regular contact with his mother recalled how he always waved goodbye to her from the first floor window of the establishment. He remembered one occasion when he was going to the window to wave to her as usual, a member of staff stopped him, asked him where he was going and said, "Stop your nonsense." He was especially upset as he knew his mother would be waiting for him to wave as usual.

Bullying by Older Residents

124 Applicants recounted bullying by older residents as a cause of emotional abuse. There were descriptions of older boys being placed in charge of the younger children without appropriate adult supervision in place. One applicant referred to the older boys as devils, and said that the younger children went "through hell" adding, "you could hear their terror".

Exposure to Fearful Situations

125 Some applicants alleged that some of the staff deliberately tried to scare the residents; for example, several applicants referred to residents being thrown into an outdoor swimming pool despite staff knowing they were unable to swim. One applicant alleged that he was thrown into the deep end of this pool and older boys had to rescue him. There was reference to a boy who could not swim begging the staff member not to throw him into the pool, "Please, I'll give you a shilling from my pocket money to stop." This applicant commented that the member of staff could sense the fear in some of the boys and appeared to take pleasure from seeing their terror.

126 Several applicants referred to a staff member in one establishment who wore a white sheet over his head and looked through the windows when they were in bed. One applicant remarked that this may have been seen by him as a harmless prank but the outcome resulted in young children being frightened. One applicant spoke of a staff member regularly driving a tractor towards him and pushing him towards an electric fence, laughing as he did so.

General Emotional Abuse

127 Some applicants said that staff threatened them with being sent to more restrictive establishments such as a psychiatric or penal establishment. Applicants recounted Christmas parties or receiving gifts from different charitable organisations but alleged that the toys were immediately removed, not to be seen again. An applicant recalled an older brother visiting from abroad bringing toys and clothes. Once his brother left, these items were removed.

128 Another applicant made the distinction between those who had been in care for long periods of time or all of their childhood and those who had some experience of family life. He commented that those who had been subject to long-stay care were "already programmed", adding, "I may have

come from a crappy home but I always had that frame." This applicant further suggested that those who had spent long periods of their formative years in care establishments were perhaps inclined to be more compliant and accepting of the harsh treatment as they had known nothing different.

129 Applicants summed their experiences up as follows:

> "I never heard so many boys crying. It was all about control – no affection, no community, and no balance."
>
> "You could smell the fear in that place."
>
> "It was a big stigma of being a home boy…we were in isolation and that formed you to be different from society."
>
> "They didn't treat you nice…it was like how an animal would be treated."
>
> "There was no love, life was just a ritual."
>
> "It was pure torture."
>
> "If one person broke the rules, everyone had to do the punishment."
>
> "Expressing feelings was discouraged and encouragement a rarity."
>
> "Fear was put into you from day one…What was done in the home stayed in the home."

Neglect: The Nature and Extent of Neglect

130 Forty-eight male applicants made 50 reports concerning the neglect of their care and welfare in seven establishments in voluntary provision. The largest number of complaints (fourteen) concerned inadequate staff/supervision, excessive work demands (nine) and inadequate diet (eight). Complaints were also made about inadequate medical attention, inadequate education, inadequate clothing and footwear, poor hygiene practices and inadequate heating and bedding.

Diet

131 The reports of poor food came from applicants who were placed in establishments in the late 1950s and early 1960s. Some of the applicants said they were in receipt of a school meal and this was a main staple in their diet. One applicant recounted that "I experienced hunger many a time", and recalled an incident when a resident who received special treatment threw his orange peel away and the boys fought to get it.

132 An applicant recounted that the staff ate well but the residents' food was poor and they were often hungry. Applicants, whose establishments had

adjoining farms with livestock, said they saw little meat other than that which was cooked for the staff. An applicant commented that the staff had a finely laid table with a big bowl of fruit in the centre: "that was very different from what the children received." One applicant reflected that although the food was plain and lacked variety, it was acceptable while others referred to the food being poor in quality and quantity. One applicant commented that there was no difference in the food no matter what the occasion: "no allowances for Christmas".

Clothing

133 Some of the applicants described the clothing they had to wear as "hand-me-down" and "ill-fitting". One applicant, who recounted being made to wear boots that were too small, said that the first person to the locker room, where the boots were kept, got the "pickings" leaving younger children disadvantaged. This applicant said that he had to walk to the farm in boots that were too small and felt great relief when he took off his boots and his bare feet touched the earth. The lack of protective clothing for working outside was a common concern reported by applicants.

Heating and Bedding

134 Most of the applicants did not mention the heating and bedding in their establishments. A few applicants remembered being cold and said the dormitories were freezing with some commenting that in winter there was frost on the inside of the windows. One applicant recalled the boys writing their names on the inside of the frosty dormitory windows.

Education

135 Those applicants who complained about their education felt that care staff did not value their education. A major concern mentioned by applicants concerned the low level of expectation regarding their potential to achieve. Several applicants said they had no memory of sitting the 11-plus and those who did, said they were not encouraged to study and there appeared to be an acceptance that they would not do well. One applicant said that he remembered being asked on occasion if he had finished his homework, but no one ever checked to see how well it was done and he was afraid to ask the staff to help. One applicant said he overheard a conversation when a teacher asked a care worker if the children would be doing the 11-plus and she replied that they would not be as, "they are all stupid".

136 Several applicants said that they worked instead of attending school. Another applicant alleged he worked in the laundry and on the farm and was not sent to school. One applicant said he enjoyed working and he always volunteered as "it was better than attending school." One applicant said that prior to his admission into a large establishment, he had been achieving well in school but once he entered care, the standard of his work declined.

137 In general, applicants described their education as deficient and some said they were unable to learn because of the climate of fear in which they were living. Other applicants commented that some of the teaching staff were not interested in their educational development and gave them no encouragement to learn. Many applicants said they left school without qualifications and some said they could hardly read or write. Applicants said that the lack of literacy skills was an embarrassment to them in adulthood and many found ways of hiding this from others.

Excessive Work Demands

138 Some of those applicants who complained of having to work when in care said they were given cleaning duties; others said they were made to work on the farm. Applicants from two large establishments said the work on the adjoining farms involved picking potatoes and baling hay. Some applicants alleged they were hired out to neighbouring farmers and described this work as difficult as it was heavy and they were cold as they were not supplied with appropriate clothing. One applicant commented:

> "It was dark when you went there and dark when you returned."

Several applicants recounted they received small amounts of money for their labour:

> "There were 86 boys in four groups who went potato picking…I think we got two shillings and sixpence every day and we spent it in the tuck shop."

Another applicant remembered picking potatoes for two weeks and asking the farmer for a hen, which he gave to him. He was allowed to keep it and built a hut for it and in due course had an additional two dozen hens which he and another boy looked after. Although they collected many eggs the boys never got any rewards – they all went to the staff. One applicant alleged that he had to work on the farm before he went to school, regardless of the weather.

139 Applicants made the following comments about cleaning and farm work:

> "I was a 'cleaner upper', having to lay the table, work in the laundry, tend to the garden and set the fire."
>
> "I was not appropriately dressed for working outside and peed on my hands to try to warm them up."
>
> "I had to pick potatoes in all weathers, gather hay, polish floors and help with the laundry."
>
> "I was working from around nine years of age, doing the laundry, washing and ironing."
>
> "I had to polish the shoes, wash the dishes, make the beds and, in later years, tend to the animals on the farm and dig potatoes."
>
> "We had to polish and clean floors every Saturday. One day I was set inside a boiler and made to clean it with a wire brush; I was not wearing protective clothing."
>
> "We were kept in on Saturdays to polish the dormitory with rags on our feet. I remember being supervised and always being told to hurry up."
>
> "On weekends we had to work including polishing the floors with blankets tied to our feet – it was fun but hard."

140 Several applicants made no reference to having to work when in their establishments. Some others who did regarded their chores as neither excessive nor onerous. One applicant recounted having to pick potatoes and cut the grass by hand, but he had no complaints as he said he "liked to be kept busy".

Knowledge of Abuse

141 Applicants reported that the staff and residents were aware of much of the abuse as it occurred publicly and was very much a part of everyday life in the establishments. Applicants said that among those who witnessed abuse were other residents, ancillary workers, care staff, teachers, instructors and those in charge. Applicants understood that their peers were too frightened to intervene and some remarked that anyone who did intervene would face severe consequences. Some applicants spoke of their guilt, both at the time and now, prompted by their failure to intervene particularly when the child being punished was a younger sibling.

Disclosing Abuse at the Time

142 In most cases applicants felt unable to disclose their abuse at that time and generally did not talk about what they were experiencing. One applicant posed the question "Who could I tell?".

143 A number of applicants said they did try to talk about what was happening to them but felt they were not believed. In total sixteen of the 75 male applicants disclosed some information about their abuse when it happened or shortly afterwards. The following indicates the role of the persons they told and whether or not they felt believed:

- Seven applicants told their parents/guardians and felt they were believed in five cases
- Three applicants told a person in authority and felt they were not believed
- Four applicants told the police when they were returned after absconding and all felt they were not believed
- Two applicants told other residents and felt believed.

Methods of Coping with Abuse and Strategies used by Alleged Abusers

144 The table that follows sets out the ways that applicants coped with their abuse while in designated establishments. Many described more than one way of coping, so the total recorded is greater than the actual number of applicants. The table also shows the strategies used by alleged abusers to achieve compliance as described by the applicants. There is no correlation between the separate parts of this table. Many applicants said that more than one method was used by some alleged abusers to ensure compliance.

Method of coping	Applicants	Strategies used by alleged abusers	Applicants
Accepted abuse as normal	53	**Actual violence to child**	63
Fear (personal and general)	87	**Atmosphere of general fear**	82
Did not know what to do	76	**Authority of older person**	59
Ran away/tried to run away	21	**Told not to tell**	10
Withdrew into self	22	**Bullying**	17
Enuresis	15	**Bribery**	9
Self harm	8	**Grooming**	5

145 Male applicants reported that fear of being beaten was a constant feature of their lives in their establishments. They described being in a state of hypervigilance, constantly aware of where they were and who was around them. Applicants described their inability to be spontaneous in their dealings and relationships with other residents and staff. The following comments illustrate commonly expressed views:

"I was always watching…looking over my shoulder. I still do it."

"I have a big regret that I stood there, frightened…I did nothing."

"I can't trust anyone who has authority over me…not the police, not social workers. I rely on myself."

"I was only a child…I knew nothing…I didn't know what was happening was wrong."

Females: Voluntary Provision

146 In total, 70 female applicants who were resident in establishments in the voluntary sector from 1956 to 1975 and who recounted their experiences to the Forum complained of experiencing abuse during their placements. Some applicants alleged experiencing one category of abuse by more than one alleged perpetrator; for example, one may have alleged physical abuse by two or three alleged abusers and may also have reported emotional abuse by one of them or by someone else. The 70 applicants spoke of abuse in fifteen establishments. The following table sets out the combinations of types of abuse they alleged.

Abuse types	Applicants	Establishments
Physical, emotional, neglect and sexual	10	4
Physical, emotional and neglect	25	6
Physical, emotional and sexual	2	2
Physical and neglect	2	1
Physical and emotional	6	4
Physical and sexual	1	1
Emotional and neglect	7	6
Emotional and sexual	1	1
Emotional, neglect and sexual	1	1

Abuse types	Applicants	Establishments
Emotional only	8	7
Sexual only	1	1
Physical only	3	3
Neglect only	3	3
Total	**70**	**40 (15 different establishments)**

Physical Abuse

147 Forty-nine female applicants described being physically abused in nine separate establishments. They reported 91 instances of physical abuse. The following table sets out the extent of reports of physical abuse per establishment.

Applicants	Establishments	Reports/instances
30	1	65
8	1	16
3	2	4
2	1	3
4	2	2
2	2	1
Total - 49	**9**	**91**

148 Physical abuse was most usually reported in combination with other types of abuse with an exception of three applicants who reported physical abuse only. These three applicants were in three separate establishments.

Descriptions of Physical Abuse

149 Applicants described being physically abused in a variety of ways, including being beaten, slapped across the face, and punched across the head or shoulders, being pinched repeatedly and being kicked. The Forum was told of instances where applicants had their heads knocked against walls and school desks. Being pulled by the hair across the classroom was reported by some and was said to be very painful. A few applicants also mentioned being swung by their hair.

150 There were frequent references to having to kneel for long periods as a punishment. Applicants said that this happened more often at night and the darkness added to the distress felt. Some described being locked in

confined spaces, usually after a beating, and this included being confined in cupboards, under the stairs and in outside sheds. There were also reports of being struck with implements including leather straps, rulers across the knuckles, metal spoons, wooden spoons, wooden hairbrushes, sticks, slippers, a piece of wood, bamboo canes and bunches of keys. Many applicants reported being beaten every day while others spoke about specific incidents where the punishment was particularly severe. They reported being physically abused by religious and lay staff as well as by other adults employed in the establishments. There were also reports of physical abuse by older residents who were put in charge of younger children. The following descriptions and direct quotations from applicants are indicative of the information given to the Forum.

151 An applicant said that a staff member beat her in school with a bamboo stick across the legs. She was hit frequently, almost daily. She was hit with a cane on her knuckles or the palms of her hands. She said she was struck on her face and her hair was pulled. She also described being hit on the head with a hair brush. She recalled a very harsh beating that she received when she stayed on at school, against staff wishes, to take part in a school entertainment. She said she was beaten badly. She was also beaten for wetting the bed. This attracted particularly severe punishment. Her older sister often changed sheets with her to try to pre-empt her being beaten.

152 Another applicant described beatings as a daily occurrence

> "...I just took it as the norm – if I had mentioned it at the time who would have believed religious people would do that?"

Hearing other children being beaten was reported frequently and was described as particularly distressing; one applicant recalled an incident when she heard a staff member beating a child in the cubicles in the toilets:

> "she was screaming...it was just awful...you were pleased it was not you but it was horrible..."

153 An applicant, placed in an establishment in the 1970s when she was in her teenage years, described being beaten with a bamboo cane across the palms of her hand. She spoke of the cane snapping and the staff member commenting "there's plenty more where that came from". Another cane was produced there and then. This applicant also described a regime of being beaten and seeing other children being beaten and referring to the situation as one of control, guilt and fear.

154 Bed-wetting attracted very frequent punishments:

> "I was hit around the head and…all over my body…I had to stand up for a long time, for ever…in front of everyone. Staff beat you…I don't know the names, I can't remember."

155 One applicant spoke of the daily experience of being hit for no reason:

> "It was a good day when you were not hit…I kept quiet, said nothing; I was hit whether right or wrong…the member of staff who did it was a very angry person. She got red in face when angry. The children knew her moods."

156 Another applicant, who spent eleven years in one establishment, spoke of being beaten repeatedly throughout that time for bed-wetting, and for any and every misbehaviour, no matter how small, and for none. She described how her face was pushed into her wet sheets. She finally left the establishment in 1975 when she was sixteen. One applicant summed up the feelings expressed by many saying:

> "There was a total lack of love or affection; it was a very intimidating environment where you were consistently treated in a demeaning way and told that you were worthless. If you tried to have any fun the staff would come down on you straight away and suppress any fun."

157 The most commonly reported circumstances that led to physical punishment were: bed-wetting, talking during the many periods of the day when silence was demanded, failure to complete tasks either in the classroom or the allocated work in the establishment, left-handedness, having fun or refusing to eat the food at meal times. Coughing and talking in church were particularly frowned on. As girls got into their teenage years any efforts they made to improve their appearance were interpreted as trying to engage boys' attention and they were punished severely. Other commonly reported reasons for being hit included the misbehaviour of younger siblings or any younger child of whom an applicant had charge and being sick (looking for notice was how staff characterised this). Running away from the establishment resulted in very harsh treatment. Soiling pants when menstruating was also dealt with severely, yet the practice in some establishments of restricting the availability of sanitary protection made it impossible to maintain cleanliness. There were times in each establishment when infestations of scabies and/or head lice were common and the treatment of having heads shaved and of having emulsion applied in a rough manner was a focus of some complaints of physical abuse.

Physical Abuse by more than one Person

158 There were multiple allegations of abuse, as follows:

- One applicant alleged physical abuse by six people
- two applicants alleged physical abuse by five people
- three applicants alleged abuse by four people
- six applicants alleged abuse by three people while sixteen applicants alleged abuse by two people.

The remaining 21 applicants alleged abuse by one person. In most instances reported the alleged abusers acted independently.

Roles of Alleged Abusers

159 The table that follows shows the position within the institution of the alleged abusers. Please note that other residents were sometimes noted as bullies by applicants but not identified on the whole by name and are not included in the table below. It was not possible to ascertain how many residents were also physically abusive.

Role of alleged abuser	Male	Female	Member of Religious Order/ Clergy
Officer in charge/ authority figure	-	38	33
Teacher/instructor	-	14	9
Care staff	2	48	42
Ancillary staff	1	1	-
Other (role not clear)	1	-	-
Total	4	101	84

It is noteworthy that of the 105 alleged abusers, 84 were members of a religious order or a parish priest.

Sexual Abuse

160 This section describes sexual abuse reported by sixteen female applicants to the Forum. The sexual assaults reported were both contact and non-contact in nature and happened both in the establishments and away from the establishments, particularly while the applicants were on holiday or with weekend families. The majority of the applicants found this aspect

of abuse very difficult to speak about; some described having tried to block out what happened for many years and feeling that they were in some way responsible for what had occurred. The secretive and isolated nature of sexual abuse coupled with the applicants' lack of knowledge regarding sexual development left many of them very bewildered and without the language to describe what had happened.

Nature and Extent of Sexual Abuse

161 The sixteen applicants recounted 31 instances of sexual abuse in respect of eight separate establishments in the voluntary sector. Fifteen applicants described sexual abuse in combination with other types of abuse while one applicant complained solely of sexual abuse.

Description of Sexual Abuse

162 The full range of types and numbers of reports of sexual abuse are set out in the following table.

Type of sexual abuse	Number of reports
Inappropriate fondling	9
Vaginal rape	3
Attempted rape	1
Anal rape	1
Oral/genital contact	3
Digital penetration	4
Masturbation of alleged abuser	3
Indecent exposure	5
Kissing	1
Witnessing sexual abuse	1
Total	31

163 Some descriptions and direct quotations from applicants are set out in the following paragraphs and are representative of the information given to the Forum. Ten applicants spoke to the Forum of sexual abuse suffered within the precincts of the establishments. Two applicants described sexual abuse by visiting clergy; one of the priests was said to have been there every weekend and an applicant described being made to wait until last to attend confession and being brought to a room in the church where she was fondled, made to masturbate the abuser and finally was subjected to

anal rape. The abuser was said to have groomed her initially by providing sweets but then turned to violence, telling her she would not be believed if she reported what he was doing. Another applicant spoke of being taken out in a red sports car by a priest:

> "three of us always went, he had sweets, and he kissed and hugged us."

164 Two instances were recounted in which applicants were working in or visiting the elderly male residents' section of the establishment. Both applicants described being fondled while being held on a resident's knees and one believed it was obvious to others what was happening. Neither spoke of staff being in the vicinity when this occurred.

165 Abuse by older residents was described by four applicants. This abuse occurred mainly in the dormitories at night when older girls would take younger girls into their bed and force them into sexual behaviour ranging from fondling to oral sexual contact and masturbation of the alleged abuser. Actual violence or threatened violence was common in these situations. One applicant, placed in a hostel for a short period of time, described being taken to an office by three male residents and having photographs taken of one of the men fondling her. This happened on more than one occasion. She was very young and appears not to have had any proper supervision while living in a mixed hostel.

166 One applicant, who had had placements in two establishments, described serious abuse by the officer in charge of one establishment who fondled and groped her, inserted objects into her vagina and forced her to engage in masturbation. The applicant was prepubescent at this time and suffered regular violence from the same staff member. There was a description of sexual abuse in an establishment involving former residents, by that stage adults, who were working there:

> "They were grabbing at you all the time…they had easy access to the dormitory…always, grabbing and fondling. It was a free for all…I learnt to run."

167 Five instances of sexual abuse reported to the Forum occurred when the applicants were staying with 'holiday families' away from their establishments. Two applicants alleged they were abused by members of their holiday families and another by a member of the extended family she was taken to visit. The alleged abuser was a member of a religious order. One applicant alleged she was raped by both the father and an

uncle of her holiday family. One applicant alleged that at age seven she was raped by the son of the holiday family who was much older than she was. On return to the family home she was put in the bath and then sent back to the establishment. She described her shock at what happened and knows she never went back to that family but does not remember if anyone else was aware of what had occurred. A fourth applicant spoke of her experience of being fondled and being made to touch the genitals of a relative of the holiday family when she was taken to see him. The fifth applicant spoke of being touched and fondled by an older son in the family and also spoke of the father in the family exposing himself to her. Three of the four applicants who were sexually abused in holiday families described their emotional conflict resulting from having formed an attachment to the mothers in the families and to other younger children while not wanting the unwelcome attentions of the males.

Sexual Abuse by More than One Person

168 One applicant reported that she was abused by four different alleged abusers; two applicants reported they were each abused by three abusers, while thirteen applicants each alleged abuse by one abuser. The table that follows sets out the roles of alleged abusers as recalled by applicants.

Role of the Alleged Abuser	Females	Males	Member of Religious Order/ Clergy
Officer-in-charge/ authority figure	2	-	1
Care staff	1	-	-
Other adults	-	3	-
Other Residents	5	2	-
Visitors	-	5	3
Members of host families	-	6	1
Totals	8	16	5

Emotional Abuse

169 This section of the report describes emotional abuse in establishments in voluntary sector provision. Emotional abuse covers a range of actions and inactions that deprived the applicants of family and sibling contacts,

knowledge of their own identity, affection and approval and protection from harm appropriate to their age and developmental needs. In their descriptions of emotional abuse to the Forum the applicants most often referred to practices and routines, for example, the separation of siblings and the removal of all personal belongings or signs of individualisation from the children, both on admission and throughout their stay in establishments. Emotional abuse as such was not often ascribed to individual staff but was generic and systemic in nature.

Nature and Extent of Emotional Abuse

170 Emotional abuse was the form of abuse mentioned most frequently by the 52 female applicants in this Period. Those applicants spoke of emotional abuse in twelve separate establishments in the voluntary sector. Forty-four applicants reported emotional abuse in combination with other types of abuse while eight applicants reported emotional abuse only. The range of emotional abuse described in the twelve establishments was as follows.

Type of emotional abuse	Number of reports
Shown no affection	18
Public humiliation	15
Personal denigration	19
Removal of personal belongings	15
Family denigration	15
Family contact discouraged	19
Sibling links discouraged	15
Inappropriate exposure to fearful situations	22
Other	9
Total	**147**

171 The recorded instances of emotional abuse are those of which the applicants were most keenly aware. They described the impact of that abuse on them both at the time it occurred and in their lives afterwards. The emotional abuse described to the Forum fell into three main categories: personal abuse both in private and in public; separation from and denigration of family and siblings; and inappropriate exposure to fearful situations. A small number of reported experiences were outside those broad categories and are dealt with separately.

Personal Emotional Abuse

172 This was the focus of 67 experiences of emotional abuse described to the Forum. Applicants spoke of:

- having their personal belongings removed, including small tokens that were all they had to help them remember family or home, and
- experiencing public humiliation in front of their classmates, their group in the establishment, the church congregation or wherever they happened to be.

One applicant spoke of her experience during a two-year placement:

> "I was constantly told by staff that I was unworthy...nobody wanted me...she (staff) constantly reminded me...'your mother is no better than a tramp'...We were all called by our surnames – never by our individual names."

This applicant spoke also of the removal of clothes and money given to her by foster families on her return from short stays with them and said she never saw the gifts again. She described her placement overall as a very cold place, where no affection was shown.

173 Another applicant spoke of the difficulty she experienced with a senior staff member whom she believed had a grudge against her from early in her placement:

> "She always made remarks: 'Aren't you the clever girl' but I never knew if she was being sarcastic or genuine."

She further described her inability to do something right for this staff member:

> "...if you looked her in the eye when being spoken to you were called defiant but if you failed to look her in the eye you would be reprimanded for being insolent."

This applicant ran away after a severe beating and was returned to the establishment. She recalled that the same staff member then called her "Lady (family name). Oh we're not allowed to hit you now."

174 Another applicant talked about the daily denigration she experienced in relation to bed-wetting and the public humiliation involved:

> "...I was told on a daily basis by staff 'you are smelly...nobody could love you...why do you think anyone would want to sit beside you'...that was the constant refrain."

She described the morning ritual for those who wet the bed; all had to stand in line and then had to walk from the bedroom to deposit the wet sheets in a basket; she described it as being "like a ceremony…everyone saw it." Another applicant described the weekly routine in which underwear was inspected:

> "They (two members of staff) had each girl hold up the gusset of their knickers for inspection…I never understood the purpose of this."

175 The removal of personal possessions was keenly felt by many applicants and the following accounts are typical of the accounts given:

> "Everything you got was taken off you at the door…I got money for Communion, it was two shillings and sixpence. I got sweets to bring back to sisters…all were taken…there was no explanation."

Another applicant was deeply distressed by the removal of a doll her mother had given to her. She explained that her family was poor and despite that her mother had managed to get this doll for her. It was very special to her and she felt its loss doubled the loss she experienced when coming into the care system: "I can still see it and almost feel it."

176 One applicant spoke of being constantly told her mother did not want her and that she and her brother should be grateful they were in the care of the establishment.

Although she could go home at the weekend for a day, one applicant explained why she chose not to go on some occasions: a senior staff member always told her to ask her parents for money. When she returned with no money she would be publicly berated:

> "We can't afford to keep you…Do you think we are a charity?"

Family Denigration and/or Links Discouraged

177 A second area of emotional abuse keenly felt by applicants covered the separation from siblings even within the same establishment, the poor treatment of families who visited the establishments to see their children, the lack of privacy during those visits and the active discouragement and the discourtesy shown to parents who were seen as "undesirable". In particular, applicants whose parents were members of the Traveller community reported that this was a common occurrence and that they were neither welcomed nor wanted by the establishments.

178 Applicants said that strict control was exercised over all family visits. Visits were never actually encouraged but when family members visited

they were supervised, even where it appeared there was no threat to the child or young person. As one applicant recalled "Aunt D visited…staff always sat in…we couldn`t be ourselves." If there were concerns over the appropriateness of some visits by parents to see their children, this was never explained and applicants were told simply they could not see them. Some applicants saw their parents treated differently to other visitors:

> "They made our mother wait out in the cold…she had travelled hours to see us…barely time to say hello…then out the gate."

Another applicant spoke of her mother's occasional visits,

> "She got no welcome…she had to come to the back door where we fed the poor…we were made to be ashamed of her."

179 One applicant from a large family spoke of her joy when her father called in but she learned later that the staff

> "were angry with my father for dropping off small bags of oranges for us…when we went out for weekend we were told to ask for money."

There appeared to be no understanding of the sense of loss and upset children felt during visits and a number of applicants spoke of visits being stopped because they displayed upset when parents left.

> "Father came up…my younger sisters cried…they stopped him coming as the girls were upset when he left."

180 Another applicant said that she was not told why she was being taken from her family and placed in the establishment. She had very strong links with her grandmother who would visit her but when her grandmother died the staff did not tell her and she only found out sometime later. She was very upset for a period of time but got no emotional support. When her crying was judged to be out of control

> "…they instead placed me in an isolation room…we were meant not to feel…to be like them."

181 The major cause of upset for many applicants was the separation from their siblings. Sibling groups were often placed in establishments, rather than being brought up separately within extended families, because parents wanted them to remain together. The structuring of most establishments into gender and age groupings ensured that did not happen and many of the applicants spoke of the distress this caused, and continues to cause, as they lost knowledge of and closeness to their sisters and brothers. One

applicant who was older than her siblings and whose mother believed they would be kept together, spoke of what happened:

> "In the event we…(she and one sister, the boys were gone)…were taken to a lobby in (named establishment)…I was distraught with worry about the others."

She described being frightened by the austere surroundings and alarmed that no one would listen to her when she approached them to ask about her siblings. That fear and anxiety was to stay with her, she told the Forum, throughout her two years in the home. One applicant said:

> "I did nothing but cry all of my childhood…I didn't see much of my sister as we were separated, I just remember her screaming a lot."

182 Another applicant, who was part of a large sibling group, found the absence of her older sisters very disturbing. The older girls were placed in another part of the building and she wanted to go to them for reassurance and comfort. This was not allowed by the staff. One applicant described how she saw her siblings:

> "…I was only able to see the older ones through railings separating playgrounds. Sometimes I saw them when we went to church…I would shout for them to join me but they were never allowed."

Other applicants spoke of seeing very little of their brothers and sisters who were in the same or adjacent establishments. They might see them on Saturdays if allowed to go downtown, or at school but no effort was made to get them together and gradually all contact was lost. Younger children were often described as forgetting they even had older sisters or brothers.

183 One applicant summed up what many said to Forum:

> "…family, brothers, sisters….relationships were not encouraged at all…I ended up not knowing them…they ended up not knowing me…I was not allowed to say goodbye when I was discharged…I knew I was not welcome to return to see those left behind."

Exposure to Fearful Situations

184 Applicants described being locked into small spaces with no light, often with restricted ability to move and being terrified they would be left there to die or just be forgotten about. One applicant spoke of being put into a hot press/drying cupboard for sheets; she described:

> "it as very dark, no place to move as there were bars across for putting sheets on."

She said she was put in twice as part of the same punishment and described herself as "being scared to death."

185 Another applicant told the Forum about the staff member who was always talking about the devil.

> "She (staff member) had a thing about the devil…She had a stick for the window with a hook on it…she would open the window to let the devil out, she once told me she saw the devil dancing on my locker…it terrified me for ages."

This applicant also described the practice whereby children had to sleep at night with their arms crossed, hands on shoulders so that, if they died during the night, they would go to heaven. They were told that if their arms were not crossed they would "burn in hell." Many applicants placed in institutions during the 1950s and early 1960s were told to sleep in that position and were given the same explanation.

186 Another experience recalled by some applicants was the practice of preparing the dead for burial, referred to as "laying out the dead." This was described in a small number of institutions where retired staff members were resident and also where there was residential provision for older people in another part of the establishment or in adjacent accommodation. One applicant remembered:

> "When old people died in the annex I had to go and see them and pray for them…I was often left in the room with another child or on my own…I wondered if they might wake up…I didn't know what death was."

Another applicant said:

> "…I was made to go and dress the dead and say a prayer…I had to lay the men out in brown shrouds and the woman in blue shrouds…I was always terrified."

187 Another applicant described her punishment for some misdemeanour as follows:

> "Staff locked me in the dining room with a bird that was there, it was flying widely about…there was no furniture in the room as it was being done up…I wet myself and was terrified."

188 Some applicants told the Forum of the fear of being sent away to more restrictive establishments. They explained that both implicit and explicit threats were made that they would be sent to a psychiatric hospital or to a laundry. They understood they would be kept in these establishments indefinitely. The threats described were most often made in reaction to episodes of absconding. Two applicants recounted their experiences:

> "I ran away, I was brought back, I ran again…one time after the usual treatment (physical punishment) she (staff member) pushed me up against the wall…'just wait…leave again and you will be sent to (named establishment)…you won't leave there so fast'…I knew she was not just threatening me…others had gone."

Deprivation of Affection

189 Lack of affection was generally described by applicants as the absence of a kind word, never being praised or encouraged, never having any distress acknowledged and being unable to talk to anyone when hurt, ill or unhappy. When children tried to get attention for any of those reasons they were said by staff to be "looking for notice." Comments made by applicants in their meetings with the Forum included the following:

> "No one took the time or effort to make you feel comfortable and at ease."
>
> "There was no love, no kindness at all, no love no nothing – just like a prisoner not even thought about, I don't think they even ever called you by name…It was very unpleasant I wouldn't put my worst enemy in it."
>
> "Lots of bullying and neglect, abusive shouting all the time, I was isolated from my siblings who were in the same institution. I was always crying, I was cold and hungry all the time…I listened to others crying all around me, no comfort was given."
>
> "I was never shown affection…I felt ignored all my childhood."

General Emotional Abuse

190 Many applicants spoke of an atmosphere that was cold and forbidding. One applicant who described herself as "a pet of the officer in charge" said she recognised that everyday life in her placement was ruled by the regime that was in place and that there was no understanding from anyone. Another applicant spoke of having had to keep her eyes downcast when staff passed or spoke to her. An applicant who was placed in a laundry as a thirteen year old, described being put to work and deprived of a normal education. She said:

"...I lived in a suffocating environment where normal teenage life was not available and where everyday life was deliberately excluded by them."

191 Finally, an applicant spoke of the consequences of being prevented from having normal social interaction with other girls. She said that, if that had been allowed, she could have expressed feelings such as those prompted by the loss of her granny and her separation from her two younger brothers to whom she had been like a mother. She commented:

"Each girl learned to keep to herself...no friendships were allowed."

Neglect

192 Thirty-five applicants made 57 reports concerning the neglect of their care and welfare in twelve establishments designated as voluntary sector provision. The 35 applicants complained of neglect as follows:

Type of neglect	Number of Reports
Inadequate diet	7
Inadequate clothing/footwear	7
Poor hygiene practices	7
Inadequate medical attention	5
Inadequate heating/bedding	5
Inadequate education	8
Inadequate staffing	2
Excessive work demands	9
Lack of supervision in institution	4
Lack of play opportunities	3
Total	**57**

Diet

193 There were seven reports of poor diet made to the Forum. Some applicants spoke of poor quality food while others spoke of regularly going hungry. Some examples are given below:

"There was donated food but this was not given...to us. I ate from the gutters and picked chewing gum off the ground...I was always hungry."

"The food was poor quality, there was not enough, I was always hungry, I was forced to eat semolina and bread pudding even though this was

nauseous. Salty, lumpy porridge and bread with dripping was the main diet with scraggy meat now and then."

"If you refused to eat food like inedible fat, gristle and burned food, they would take it away but then bring it back until you ate it. I wasn't starved but I was hungry and would steal food if the opportunity arose."

"The food was bad – porridge, bread…the children could smell the lovely food such as roast beef being cooked for the staff."

The majority of the reports concerning poor diet were made by applicants who were placed in voluntary establishments from 1956 to 1969. There were few complaints about diet in relation to provision in the period 1970 to 1975.

Clothing/Footwear

194 Seven reports of inadequate clothing and footwear were made to the Forum. The clothing provided for some applicants was described as consisting of a dress with the sleeves always rolled up and with an apron worn over it. There were some references to having smarter clothes for going out of the establishment. Clothing, including footwear, was said to have been shared and was often ill-fitting or already well worn when applicants received it. Applicants told the Forum that although school uniform was provided "it was different from the others". The following quotations are taken from applicants' accounts of their experiences.

"The shoes were too big, they often had holes, nails were often protruding. It was a free-for-all grabbing shoe; you were lucky if you got a reasonable pair."

"We were given pinafores, all second hand; you were made to wear size seven wellingtons in wet weather regardless of the size of your feet…we didn't matter."

"Although I had been provided with clothes by an aunt and uncle, these were taken from me and I was given old fashioned clothes to wear and…used footwear."

"…not having any socks at all…it was very cold."

Education

195 Primary education for most of the female applicants in voluntary establishments was provided on the premises. They received their secondary education in local schools. The eight applicants who expressed concerns about their education described the standard as poor. The complaints

ranged from being placed at the back of the class and being ignored to being called out to complete chores and so missing opportunities to learn. The following are some examples of what applicants told the Forum:

> "I went to school; I was told I was stupid. I got no assistance with my work. I was very frightened at school, and I was unable to concentrate."
>
> "At school I was always placed at the back, I was discouraged from asking questions, I was hardly able to read or write when I left school."
>
> "I was called out of class to do cleaning and when I left school I was so far behind in my work I was unable to read or write to any extent. I was very rarely in class: I would get messages from (named staff member) to do jobs instead of school work – scrub floors, clean shoes…education was not for the likes of us!"
>
> "The only thing I learned in the home…was what fear and pain were like. In school I was placed in what was known as the 'dunces' class."
>
> "Teaching in the primary school was poor and I became inattentive. When I made good progress in the pupil referral unit, my reports were disregarded and I got no encouragement."

196 Finally an applicant who was discharged to the care of her mother in England, just before she was due to take her public exams, felt cheated out of her chance to better herself:

> "I would have done well in exams and I really regret not being given this opportunity…It had a long term adverse affect on job opportunities… what difference would a month have made to them?"

Excessive Work Demands

197 Nine applicants spoke of excessive work demands being made on them from early childhood until they left the care system. This was coupled with poor staffing ratios in the larger establishments, a very high standard of cleanliness being demanded and responsibility for maintaining this being placed on the residents. Applicants' comments included:

> "From the age of eleven years we were made to work…cleaning, scrubbing, polishing…in the chapel, dormitories, long corridor, bathrooms, laundry (including for staff and old people), looking after the elderly people, pumping the church organ, putting coal in the furnace – we were treated as an unpaid skivvy."
>
> "Every Friday night five pairs of girls on their knees scrubbed corridors and the chapel. I never saw staff do physical work. I had special duties

to look after an older girl who had learning difficulties and I became completely responsible for her."

"(a member of staff) told me…we are delighted when you get punished, we get great work out of you."

Poor Hygiene Practices

198 Seven applicants highlighted the poor hygiene practices they experienced in establishments in the voluntary sector. There were two common complaints highlighted by all seven:

- The lack of privacy for bathing and the overuse of Jeyes Fluid in the baths.
- The lack of preparation for and practical assistance with the onset and management of menstruation.

An applicant, describing bath time and the lack of privacy, said:

"we were like animals in a shed lined up, one child was in the bath, one sat on the edge of the bath washing her feet, others lined up waiting their turn in the same water; the only attempt at modesty was for two girls to hold up a sheet for the girl getting out of the bath."

Another applicant described being bathed in Jeyes Fluid resulting in irritation in her eyes and skin and said that so much Jeyes Fluid was used it left brown marks on her skin.

199 Applicants commented on the lack of preparation they received for the onset of menstruation and the inadequate provision made for them during their menstrual period. Applicants told the Forum that they had to ask for sanitary towels. Staff might not respond promptly to a girl's requests but reply that she had been given a sanitary towel in the morning. No extra baths were provided for and this lack of hygiene and basic care left many embarrassed and suffering with chaffed legs. No pain relief was allowed. One applicant reported that:

"I started menstruation at eleven…it was very heavy from the start…it was not believed, they said I was too young…(a staff member) made me stay in one room supervised by…and then I was made show my pants to prove it. I fainted and was given water. I got no medical help although I suffered very badly."

Other Issues Raised

200 A small number of applicants expressed concern over other aspects of their care including heating and bedding. Five applicants, whose care placements were in the early 1960s, spoke of being cold or having inadequate bedding:

> "...my bed sagged in the middle and I couldn't lie in it in the position the staff dictated...I was always cold, always freezing, only one sheet on the bed."
>
> "I wet the bed, I was beaten, I had to wash my sheets in cold water...I often lay in cold...damp sheets."

201 Some applicants also recalled that they felt that they did not receive adequate medical attention when they were ill or injured:

> "I suffered from depression in my later years in care and despite my initial attempts at self harm, no-one tried to investigate what might be happening, no one sent me for any help."
>
> "I had a bad fall. I fell outside the sewing room; my knee split open; I was never taken to hospital. I was in pain for a month. It healed itself and I'm left with a bad scar."

202 Three applicants spoke to the Forum concerning the lack of opportunities for play and recreation. They told the Forum that few toys were provided and that the play equipment in the garden was insufficient for the number of children. The Forum heard from one applicant who said that toys were produced for inspections and when other visitors were present.

203 Four applicants spoke of the lack of staff supervision, particularly at night time and they felt that this added to their vulnerability in that it allowed older girls to remove the younger ones from their beds and sexually abuse them. Where the work chores were supervised by older girls, the situation was described as "worse than when the staff were in charge."

Knowledge of Abuse

204 Applicants were clear that physical abuse, emotional abuse and neglect were public within the establishment. They said that the staff and co-residents could not have been unaware of what was going on. Applicants acknowledged that other residents were too frightened to intervene and those who did do so were severely punished. This was most likely to happen, they said, if a younger family member was being punished in the presence of an older sister.

Disclosing Abuse at the Time

205 Generally, applicants said they did not disclose anything about their care experiences at the time. Some applicants said they did not know the abuse was wrong, some were very frightened of the consequences because they had seen what had happened to others who had spoken out, and some applicants felt they would not be believed. In total, twenty of the 70 applicants told the Forum that they had disclosed some information about their abuse when it happened or shortly thereafter.

206 The following is a list of the roles of the people the applicants reported to and whether or not they felt believed:

- Six applicants told their parents/guardians and felt they were believed in four cases.
- Five applicants told a person in authority and felt they were not believed.
- Four applicants told the police when they were picked up after absconding; they felt they were not believed.
- Three applicants told their welfare/social worker and felt they were not believed.
- Two applicants told other residents and felt believed.

Some quotations illustrate the points made by the applicants:

> "I finally told (a staff member) she (an older girl) was doing things to me…she (the staff member) was very angry and beat me."
>
> "When I told about sexual things…(to the family she had stayed with) I got the beating of my life."
>
> "I got hit less often after I ran away…I think they got worried."

Methods of Coping with Abuse and Strategies used by Alleged Abusers

207 The table below sets out the ways that applicants coped with their abuse while in the care system. Many described a number of responses, so the totals recorded are greater than the actual number of applicants. The table also shows the strategies the applicants said were used by alleged abusers to achieve compliance. There is no correlation between the separate parts of this table. Again many applicants described that more than one method was used by some alleged abusers.

Method of coping	Applicants	Strategies used by alleged abusers	Applicants
Accepted abuse as normal	26	**Actual violence to child**	42
Fear (personal and general)	21	**Atmosphere of general fear**	35
Did not know what to do	19	**Authority of older person**	31
Ran away/tried to run away	19	**Told not to tell**	5
Withdrew into self	14	**Bullying**	5
Enuresis	10	**Bribery**	4

208 For many applicants "beatings were everyday, a normal thing" and they accepted that reality. Applicants spoke also of an all-pervasive fear in many establishments that meant children kept quiet, watched out for staff reactions and tried to stay away from those they experienced as harsh. Some applicants described particular responses as follows:

> "I became an every night 'bed-wetter' which, in turn, got me...more abuse."
>
> "I would push people away, I don't trust people...I don't trust the establishment, police or teachers."
>
> "I was very isolated...not being able to talk of the abuse I lived in fear... Even in secondary school, I had no friends until my fourth year."

209 One applicant described what happened when she ran away from one establishment with her sister and stopped at a house to ask for a glass of water. The people of the house called the police, who returned them to the establishment. The policeman, as reported, remarked:

> "I suppose you are going to get a hot drink and cakes when you return to the orphanage?"

The applicant commented that the remark stayed with her as it was the complete opposite – she knew she was going to get a beating, which she did.

210 Four applicants spoke of receiving gifts from their abusers, none of whom were staff members in their establishment.

Abuse in State Provision

211 This section covers the abuse reported to the Forum in state establishments between the years 1956 and 1975. In total, twenty male applicants and ten female applicants spoke about their experiences in sixteen individual establishments in the state sector. The establishments included in this section were largely small units based in community settings. These establishments included a children's home for both male and female children and young people, an assessment centre, a residential medical setting and two hostels. Some applicants did not disclose abuse in regard to some of the state establishments in which they were placed.

212 This section of the report is presented in two parts, with the first part covering the four aspects of abuse reported by male applicants and the second part covering the four aspects of abuse reported by female applicants. The table below shows the combinations of abuse types that were reported to the Forum by both male and female applicants in relation to state establishments.

Abuse types: Males and Females	Applicants	Establishments
Physical, emotional and sexual	2	2
Physical, emotional and neglect	1	1
Physical and emotional	4	4
Emotional and sexual	2	2
Emotional, neglect and sexual	2	2
Sexual only	4	2
Emotional only	1	1
Physical only	4	2
Total	**20 (*17 individual applicants)**	**16 (11 individual establishments)**

***Note:** Three applicants alleged abuse in two establishments each.

Males: State Provision

213 Twenty male applicants had been placed in eight individual establishments in the state sector. Three of those applicants had two placements in different establishments in state sector care provision. Three male applicants had been placed in state establishments in the 1950s. Six male applicants were placed in establishments in the state sector in the 1960s. Five of those applicants had had placements ranging from one to six years in duration. One applicant spent less than one year in care. Eight male applicants had been placed in state establishments in the 1970s. It is notable that during this period, six of these applicants were in placements for a short period of time – one year or less. The other two applicants spent six years and three years respectively in state provision.

Physical Abuse

214 Eight male applicants gave ten accounts of physical abuse with regard to seven separate establishments. One applicant recounted that after he had wet the bed, a male member of staff rubbed his face in the soiled sheet, stripped him naked and forced him into a cold bath. This staff member allegedly grabbed and squeezed the applicant's shoulder, repeatedly telling him he was a "dirty boy". On another occasion, this applicant alleged that the same staff member spat in his face. One applicant recounted that he was physically abused and threatened by a staff member. This applicant referred to being "grabbed by the scruff of the neck and beaten." Following this incident, the applicant said that he ran away.

215 One applicant described a staff member using a dowel rod that was over half an inch thick to beat him. This applicant recounted that he was badly marked as a result of this chastisement. He also alleged that he was slapped around the head, shoved into the dining room and "savagely beaten" across his back and legs. He reflected that "beatings were regular events every few months." This same applicant recounted another incident when he and another boy had been truanting from school and on return to the establishment, a staff member hit him and left marks on his arms, said to be "like sergeant's stripes." This applicant said that the attack only stopped because the staff member had become tired. He alleged that he could not bend his fingers the following day and his ribs ached, commenting, "Who could I tell?"

216 Another applicant recounted that one member of staff would lift him by the ears or sideburns and pinch him on the arm and the back of the neck.

He said he was instructed not to tell the welfare when they came to see him. This applicant commented that he feels he was treated more harshly than his peers as he did not witness other residents being punished in the same way. This applicant also expressed concerns about his treatment in another establishment where a member of staff hit him on the bottom with a stick and washed his mouth out with soap.

217 An applicant recounted that he was frequently beaten with a cane. He also alleged that a female member of staff pushed his head, face-first, into a basin full of water. He said he felt very frightened as he thought this female member of staff was going to drown him. He described her as "completely losing control."

Sexual Abuse

218 Nine male applicants made eleven complaints of sexual abuse by male staff and one further complaint of sexual abuse by a female co-resident. The allegations of sexual abuse relate to four separate state establishments. The male applicants spoke of sexual abuse involving inappropriate fondling, masturbation, anal rape and oral/genital contact.

219 One applicant made allegations of sexual abuse against two individual members of staff who worked as a house father and officer in charge in the establishment. This applicant suggested that both of these staff members operated as lone abusers, independent of one another. This applicant gave a detailed account of the sexual abuse taking place when he was approximately ten years old. During the time of the alleged sexual abuse incidents, which included masturbation and rape, one of his abusers made comments such as, "you're nothing but a dirty wee boy, you can't tell nobody as nobody will believe you" and "I own you." The other member of staff who was alleged to have also sexually abused this applicant took him to his home, made him have oral/genital contact and would make comments such as "you're a good boy, I'm your daddy."

220 One applicant in another establishment, referred to the sexual abuse starting almost immediately upon his admission to this placement. He recounted being taken to a staff member's home and waking up with this male worker on top of him after the alleged sexual assault. Another applicant, also admitted to this establishment, commented that within the first week of his placement as a thirteen-year-old, the same staff member watched him whilst he was having a bath and made comments to him such as, "you're a big boy for your age." The applicant alleged that shortly

afterwards he was raped by this male care worker and this continued several times a week. At times, he was made to stay the night with him in the staff bedroom and would be "sneaked out" in the morning before the housekeeper arrived.

221 Another applicant, who was placed in the same establishment, made allegations of anal rape by another staff member. This applicant recalled being raped on a daily basis in his bedroom. The alleged abuse took place in the morning once his co-resident and room-mate had left the premises to go to work. Another applicant in the same establishment alleged he was raped on the same day he attended his father's funeral. The alleged abuser is then alleged to have commented to the applicant, "Did you enjoy that…you will next time" and "Who was a good boy?" Another applicant who made allegations of sexual abuse commented that he felt that the staff in this particular establishment viewed him as a "specimen," as if they were "looking at a meal."

222 One applicant who was placed in a medical setting made sexual abuse allegations about a male health professional. This applicant recounted being pinned against a wall by this staff member "not aggressively but tenderly" and he put his hands down his clothing and masturbated him. In the same establishment, another applicant alleged he was approximately seven years of age when he was sexually abused by an older female resident. This applicant said that on his first night on the ward, a girl aged around twelve or thirteen years old, climbed into his bed and made him digitally penetrate her.

Emotional Abuse

223 Ten male applicants reported thirteen incidents of emotional abuse during their placements in eleven individual state establishments. In general, the emotional abuse allegations referred to:

- Being fearful as they witnessed co-residents being beaten
- A lack of affection shown by staff
- Being belittled by staff, including being referred to in sectarian language
- An absence of support for familial contact.

224 One applicant said that he was told that no one would believe him if he disclosed the abuse. This applicant was sent to a psychiatric hospital and then to another large establishment as he was refusing to comply with the abuse and absconding. Two applicants said they were made to

feel uncomfortable as staff had watched them while they were having a bath. One applicant remembered being constantly told "You are a waste of space." One applicant recounted that both he and his siblings were mocked by some of the care staff and told "you might as well have no father or mother."

225 Another applicant said that he was not allowed to see his mother on a one-to-one basis. On occasion, he saw her in the distance from the establishment but was not allowed to communicate with her and this was very painful for him. An applicant described his placement as "pure torture" and recalled having to stand in a corner for a minor misdemeanour "until I dropped." One applicant said that when he misbehaved, he was made to strip and stand naked with other residents watching him.

226 Another applicant remembered being humiliated at dinnertime when a senior staff member tied knots in a bib he was made to wear as he was a "poor eater". This applicant alleged that members of staff were instructed to force feed him and this took place in the presence of his co-residents.

227 One applicant was generally positive about the staff in his placement but added that due to the high turnover of workers, he felt unsettled as "they moved on too quickly." This applicant commented:

> "once I got close to anyone and could have confided in them they were gone…There was no one to talk to, you were on your own."

Neglect

228 Two male applicants gave two accounts of neglect with regard to two separate establishments. One of the two applicants complained that there was only one bathroom, which was used by both residents and staff. This bathroom had no lock and staff frequently entered while residents were bathing.

The other male applicant complained that his educational needs were not met and, as a result, he failed to reach his full learning potential.

Roles of Alleged Abusers

229 The allegations of sexual abuse in state establishments related to abuse by male staff, with the exception of one alleged female abuser who was an older co-resident. The male staff were employed as care staff, house fathers/wardens and a male nurse and were based in a hostel for boys and a medical setting for both boys and girls. The allegations of physical and

emotional abuse and neglect made by male applicants related to abuse by male staff, with only one exception. The alleged abusers included care staff and house fathers/wardens.

Strategies used by Alleged Abusers

230 Compliance was said to be achieved by the authority of staff members. Several male applicants gave the following reasons for not reporting the abuse at the time it was happening:

- actual physical violence and the threat of violence
- being told they would not be believed if they reported the abuse
- being ashamed of reporting allegations of sexual abuse
- being frightened they would be returned to a secure setting such as a psychiatric hospital or a penal institution.

Females: State Provision

231 Ten female applicants who spoke to the Forum were placed in nine different state establishments. One of those applicants had two placements in different establishments in the state sector. All ten applicants spent a maximum of one year in each placement and for some applicants their placements lasted for a few months only. One placement was made in 1959, while the other ten placements were in the 1960s and 1970s. No abuse was reported in respect of six of the nine establishments in the state sector. Abuse was reported in respect of the other three establishments as follows:

- There was one report of sexual abuse
- There was one report of physical abuse
- There was one report of sexual and emotional abuse and of neglect.

Physical Abuse

232 One applicant complained of physical abuse in one establishment. This related to a series of incidents in a medical setting. She believed the physician in charge of her treatment was harsh, saying that he stitched a wound without anaesthetic after her suicide attempt. She further reported that she felt that the administration of electroconvulsive therapy was abusive. This applicant felt stigmatised by her stay in a psychiatric facility and reflected that the fear of this being discovered impacted on her adult life.

Sexual Abuse

233 Sexual abuse was reported in respect of two establishments by two female applicants. The first applicant was aged thirteen when she was placed in a state establishment. She was generally happy there, but described the sexual abuse that developed from the unprofessional conduct of a female staff member. The following paraphrases her account. A member of staff gave her vodka and sweets and took her out in her car. On one occasion this staff member had sex in the back of her car with a man from a nearby building site. The applicant then began absconding and once went to a nearby caravan park where she met a man and his son. This man gave her money for cigarettes and asked her to meet him later; he gave her a lift to her home area and abused her. She stayed in that area and during that time the abuse continued. The abuse was described as including fondling, masturbation of the alleged abuser and vaginal intercourse. This applicant was clear that she was happy in her placement until the incidents with the member of staff. She then started absconding and she believes this led to her abuse by an older male outside the establishment. This applicant did not tell anyone about what had occurred at that time.

234 Another applicant spoke of her abuse by a number of older residents in a mixed gender establishment. She was thirteen years old. She had been subjected to sexual abuse by members of her extended family and was a very vulnerable young person. This applicant told the Forum that, following an assault in the establishment, she locked herself in the bathroom. The officer in charge believed what had happened but remarked "it takes two". This applicant made a serious suicide attempt some time later and was admitted to a psychiatric hospital where she received appropriate help.

Emotional Abuse

235 An applicant spoke of emotional abuse in the establishment in which she was repeatedly sexually abused. She said that she received no understanding or emotional support from the officer in charge despite it being on record that abuse by members of her extended family had led to her admission to care.

Neglect

236 An applicant complained that the lack of staff supervision in the state establishment in which she was placed meant that she was not protected from multiple sexual assaults by older residents. This applicant suffered from a severe skin condition and reported that the officer in charge did not always obtain the prescribed medication for her or assist her in applying it.

Roles of Alleged Abusers

237 The female applicants who alleged abuse, referred to abuse by an officer in charge, one care staff member and a number of older residents in mixed gender establishments. Compliance was said to be achieved by the authority of staff members and by threats of violence from older residents.

Juvenile Justice Provision

238 Juvenile justice provision accommodated young people who were less than eighteen years of age. Most of the applicants seen by the Forum were sent to these establishments under a court order for a specified period of time. Applicants described the juvenile justice establishments in which they were placed as:

- Single gender units (six centres)
- A mixed gender centre
- Two prisons that accommodated minors.

239 Thirty-four applicants, 27 males and seven females were placed in juvenile justice establishments. Of those, 27 male applicants made allegations of abuse or neglect with regard to seven individual establishments. Three of the male applicants had placements in more than one individual juvenile justice establishments. One male applicant was placed in three individual juvenile justice establishments and two male applicants were placed in two individual establishments. Six of the seven female applicants made allegations of abuse in two individual establishments.

240 The following table shows the extent of abuse reported to the Forum in respect of nine establishments by the 34 male and female applicants.

Abuse types	Applicants	Establishments
Physical, emotional, neglect and sexual	7	2
Physical, emotional and neglect	3	2
Physical, emotional and sexual	4	2
Physical and neglect	1	1
Physical and emotional	5	3
Physical and sexual	5	2
Emotional and neglect	2	2

Abuse types	Applicants	Establishments
Sexual only	4	4
Physical only	5	5
Totals	**36 (*34 individual applicants)**	**23 (9 individual establishments)**

***Note:** Some applicants complained of abuse in more than one establishment.

Males: Physical Abuse

241 Twenty-six male applicants made 56 complaints of physical abuse with regard to six separate juvenile justice establishments. Applicants' concerns were focused on certain members of staff allegedly punching, slapping and kicking them. There were allegations that some staff used sticks, leather straps, keys and hurling sticks to physically reprimand residents. One applicant commented that some of the staff would use "anything to hand" and they "kicked us like a football."

242 One male applicant alleged that some of the staff punched and kicked him and recounted one incident when he fell to the floor as a result of the assault. The kicking continued as he lay on the ground. This applicant said that as a result of the alleged assaults by staff he was taken to hospital and, on one occasion, he was treated for broken ribs. One applicant alleged that he was hit in the eye by a resident teacher and sustained a badly bruised eye, noting, that "I never had another black eye like it in my life."

243 One applicant alleged that corporal punishment was approved by the governor in his establishment. He told the Forum that residents were held down and had the clothing on their lower body removed after which two members of staff stretched them over the gym equipment. The staff administering the punishment were alleged to have run from the back of the hall to strike each resident six times. He alleged that this punishment often resulted in cuts to his lower body and his being unable to sit down because of the pain. Another regular occurrence alleged in this same establishment was for the staff to flick the residents with wet towels when they were in the shower room.

244 Eighteen male applicants were placed in one large juvenile justice establishment. One applicant alleged that physical abuse was a regular feature in this environment and claimed that he was battered by a number

of staff including male staff, a female member of the staff group, a resident teacher and older residents. Another applicant also resident in the same establishment said he was tortured and slapped for no reason. He alleged that he was handed a live electric wire by a care worker and hit with a strap with tacks attached to it, as well as experiencing ongoing bullying by the older boys. Another applicant who referred to physical abuse as a regular feature in the same establishment said, "I had one beating after another." One applicant recalled being made to take a cold shower and a member of staff beating him with a leather strap when he was wet and naked, alleging the strap struck his face and body.

245 Several applicants, who were resident in this establishment, reported an arrangement in which staff used older boys to discipline the younger residents. An applicant said that the staff had their own "gang of boys" who were put in charge. This applicant described an incident that occurred when he was still small in stature. He was standing in a line with the other boys when:

> "two older boys slapped me on the face, told me to cry and then cry louder and then smacked again."

These boys walked up and down the line doing this to the younger boys again and again. Another applicant told the Forum that bullying by the older boys was widespread and said that this helped the staff maintain order. He commented that he was "used as a punch bag" by older boys who were good boxers and this behaviour was encouraged by one particular member of staff.

246 An applicant said that he absconded with other boys and when they returned they were made to get up on the stage while the other residents watched. They were then instructed to remove their trousers and wearing only boxer shorts, were spread-eagled over a wooden chair and a member of staff beat them with a leather belt on the legs and buttocks. This applicant was sent to a cell for three days and recalled that, apart from porridge at the start of the day, he received only bread and water.

247 One applicant recalled that he was very frightened from the commencement of his placement in one establishment through to his discharge. On his first night, staff had asked two boys to show him around the establishment. He described them as being very aggressive, asking "Where are you from… Can you fight?"

248 Another applicant said that all the boys were terrified of a particular member of staff who would patrol the premises and for no apparent reason would slap, punch, kick and beat the boys with a leather belt. The applicant said this staff member would hit "the way you would hit a man." He recounted a severe beating he was subjected to because he had dropped crumbs from a sausage roll. He said that certain members of staff, as they walked by the boys, "swung their arm to hit you around the head." An applicant referred to a staff member hitting him on countless occasions on the ear and said that he now suffers from a hearing loss which he attributes to these blows.

249 Several applicants, placed in this establishment in the 1970s, described feuding between different gangs of residents. One of these applicants alleged that he was on the receiving end of physical beatings from other residents, staff and an assault by members of a paramilitary gang. Two applicants in another establishment spoke of a military-style culture with one stating that "everything was at the double." The applicants referred to an organised activity by the staff group called "murder ball." This 'game' had no rules and staff allegedly organised the teams in accordance with the religion of the residents and encouraged the use of extreme physical violence and sectarian language.

250 The following comments were made by applicants about their time in juvenile justice establishments:

"The staff made you feel like a dog."

"I was cuffed around the ear repeatedly."

"It was a regular occurrence to be beaten on the bare legs."

"I was made to run in circles in the yard and each time I passed a member of staff, I was hit with a hurling stick."

"My hair was shaved off and I was put in solitary confinement."

Sexual Abuse

251 Eighteen applicants made 30 complaints about sexual abuse when they were in their juvenile justice placements. These applicants described being sexually abused by staff and older residents. Some found it difficult to speak in detail of their abusive experiences. Applicants said either they had not talked about their sexual abuse at all or given limited information to their partners or family members.

252 One applicant, who was unable to enter into the specifics of his alleged abuse, told the Forum that he was kept in a solitary confinement and at night time the door would open and two or three male staff members would enter, hold him down on the mattress and sexually abuse him.

253 An applicant recounted sexual abuse by two staff members and also by several older boys in a large establishment. One of the staff members in charge of the clothes store room was said to be well known for "always touching you up and pulling you towards him." Another applicant spoke about collecting clean clothes for his monthly visits home. This same staff member never allowed more than one boy into the store room at any time and when measuring the boys for clothes, would touch their genitals. This applicant also said that another member of staff took him into his room located off the boys' dormitory and attempted to rape him and made him have oral genital contact. Older residents, described as the "favourites" of staff, taunted the younger residents and made them engage in sexual activity. Fear was associated with any resistance or refusal.

254 An applicant described being groomed and sexually abused by a member of staff whose modus operandi was to provide him and other residents with sweets and cigarettes. The sexual abuse allegedly started with fondling in the television room and progressed, finally, to anal rape. The sexual abuse also took place in the "pigeon holes" where the clothes were kept and in a holiday home used during the summer months.

255 Another applicant alleged that a member of staff selected boys to sit at the back row of chairs in the television room and placed their hands under his clothing and made them masturbate him. He alleged that this was done to many boys over the years and said he had personal experience of this on a number of occasions. One applicant alleged he saw the "handsome boys sitting on (the staff member's)...leg watching television" and said his hand was inside their shorts. Another applicant said of this establishment "It was a choice between a beating and sexual abuse."

Emotional Abuse

256 Seventeen male applicants made 30 complaints of emotional abuse in regard to four separate juvenile justice establishments. Several applicants said that the stigma of being in a juvenile justice establishment was difficult to cope with, and, as noted by one applicant, his establishment was known as the "orphan home for bad boys." Another applicant described the public humiliation he felt when the residents were "marched down the street" and people referred to them as "borstal boys."

257 An applicant who had been placed in a secure setting as a thirteen year old told the Forum that he was subjected to constant bullying by staff and older residents. Another, placed in the same establishment, reported that when he wet his bed he was made to take his mattress to the hall and stand there for all to see. Yet another applicant said that he was made to kneel in front of a religious statue in the middle of the dormitory and was publicly denounced by staff for bed-wetting. An applicant recounted that following his return after absconding, the sleeve was removed from his shirt, the legs of his trousers were cut off and his belt and shoe laces were removed. He was taken to the local cinema with other residents and spoke of the shame he felt as he had to hold his trousers up as he shuffled along and tried to avoid his shoes falling off.

258 Several applicants who had been in a large juvenile justice establishment described being threatened by staff who told them that they would be sent to a prison with older boys who would beat them. Applicants said that witnessing other residents being physically and sexually abused was very upsetting. They reported that the belittling and ridiculing of the boys was common "day in and day out."

259 One applicant alleged that he lived in a constant state of fear: "I was always looking over my shoulder or listening for the sound." This applicant alleged that this inappropriate treatment of residents was, on occasions, the result of some of the staff having "hangovers or being in a bad mood." An applicant referred to having "no association" (denied contact with others) and described the establishment as having a "rough regime" commenting "I was only fifteen, it was a hard machine." One applicant said that as a result of the emotional abuse, "they made you feel worthless."

Neglect

260 Most applicants did not comment on the general care conditions in juvenile justice establishments. However, ten applicants complained of neglect with regard to two individual establishments. Eight others each made one complaint of neglect and two individual applicants made two complaints each of neglect.

261 Applicants' concerns focused on the food being inedible or the portions provided being too small, at times leaving them hungry. An applicant said that he was deprived of food for minor misdemeanours, citing the following example:

"We were often pulled out of line in the canteen for talking or if pushed by someone, and then we got no food."

One applicant described the food as "terrible…the only time you could eat it was when the inspectors visited and we got sausages. For breakfast, we got a bap with a small knob of butter…I don't remember lunch but the evening meal was a dollop of mashed potato with beans or peas or egg."

262 Three applicants said that the education they received was substandard. One commented that, when placed in an establishment, he was more advanced than his peers, particularly in maths, but was sent to the woodwork and pottery classes instead of being provided with appropriate academic education. One applicant said "I was out of the classroom more often than I was in" and missed much of his education as he was made to act as a "lackey" for one particular member of staff. One applicant suggested that the staff "had no interest in teaching us." One applicant said he was unable to concentrate in the classroom as he was so terrified of a particular member of staff.

Roles of Alleged Abusers

263 The male applicants identified 22 male care staff, one female member of the care staff, prison and police officers, a teacher, a visiting clergyman, a night watchman and older residents as those who had abused them. In the main, the male applicants described an environment characterised by fear with the use of extreme physical force by staff and older boys. Most of the applicants said they either accepted the abuse as normal or they simply did not know what to do to stop it from happening. Seven of the male applicants said they had tried to run away but were returned and punished for absconding. One applicant said:

"I would hook it over the fence but didn't get very far."

Four of the male applicants said they had self-harmed during their placements in juvenile justice establishments.

Females: Juvenile Justice Provision

264 Seven female applicants spoke to the Forum about their placements in two different juvenile justice establishments. All seven applicants had one placement each in one or other of these establishments. Three of the applicants had had previous care placements in the voluntary sector. Two of the placements began in the 1950s and the two applicants were in

their establishment for nine and six years respectively. Three placements commenced in the 1960s and two placements were made in the 1970s.

265 One applicant did not report any abuse in relation to her juvenile justice placement. The other six applicants reported abuse in respect of two establishments as set out below.

There were

- five reports of physical abuse
- five reports of emotional abuse
- four reports of neglect and
- one report of sexual abuse.

Physical Abuse

266 Five female applicants complained of eighteen instances of physical abuse in two juvenile justice establishments. The abuse complained of included:

- being kept in solitary confinement for long periods
- being beaten by staff members and by older residents
- having hair shaved by a staff member (named) despite a scheduled participation in following days at a Feis.

Comments made by applicants included:

> "I was punched, I had bruises (from an assault by an older resident). The staff turned a blind eye. I had reward marks docked so I didn't go home. I suspect that was to stop my parents seeing the bruises."
>
> "I was made to carry my younger sister down the fire escape in all weathers to access the laundry where she had to sit in a cold bath for bed-wetting. The laundry could be accessed indoors. If I refused I was hit around the face and head."
>
> "The staff caned us on our hands for bed-wetting. We had chilblains… we were in agony."
>
> "A member of staff used her knuckles to beat me from my fingers, up along my hands, up over my head and face and down my back…all for bed-wetting…the more they beat me the more I wet the bed."
>
> "The staff beat us with wooden spoons every day after breakfast for bed wetting."
>
> "I was made to eat beetroot which I couldn't. I was sick on the floor and then hit for soiling the floor."

Sexual Abuse

267 Sexual abuse was reported by one female applicant. The applicant was aged fifteen when she was placed in the establishment. She described how she and others were groomed by a visiting entertainer; he would take selected girls into a classroom and give them cigarettes for "sexual favours." The girls were not allowed to smoke and if smoking was detected they would lose reward points. The applicant did not describe the sexual abuse in any further detail.

Emotional Abuse

268 Five female applicants described emotional abuse:

- three applicants spoke of emotional abuse in respect of one establishment
- two applicants recounted emotional abuse in respect of the second establishment.

269 Seventeen instances of emotional abuse were reported to the Forum including: being shown no appropriate affection, personal denigration, the removal of personal effects, experiencing public humiliation and being exposed to fearful situations. The following descriptions were given by applicants:

"You're nothing, I went in feeling a nobody and came out feeling worse."

"There was no positive affirmation. They were always shouting and screeching at you."

"My brothers were in care in a home nearby; I was not taken to see them. My older sister who was a lone parent came to see me and was not let in."

"I was terrified as I watched absconders being thrashed. Fear was a constant companion."

"I was not told of my granny's funeral and not allowed to attend. I was heartbroken as she had cared for me for years…why would you do that?"

"No members of staff showed any interest in helping or supporting me. I spent all my time crying."

"Staff would talk about you in the presence of other residents who would then use this as ammunition to bully you."

Neglect

270 Four applicants made ten complaints concerning neglect in two establishments. The neglect complained of was as follows:

- three complaints of inadequate medical attention
- two complaints concerning poor diet resulting in often going hungry
- two complaints of poor hygiene practices
- two complaints of inadequate bedding
- one complaint of inadequate staff supervision.

The following comments are indicative of the complaints of neglect made to the Forum:

> "I was placed in a cell with a bedstead and mattress…this had to be removed during the day. When I arrived I was made to strip and wash in a bath…I was supervised with no privacy."
>
> "I was placed in an empty dormitory on my own and had to sleep on a mattress without sheets on the floor."
>
> "The food was very poor. I couldn't eat the meat as I had seen maggots on it…I was just hungry."
>
> "Older girls were allowed to bully and abuse other residents…the staff did nothing, they turned a blind eye."

Roles of Alleged Abusers

271 The female applicants identified three persons in authority, two care staff members, older residents and a visiting entertainer as those whom they alleged abused them. The applicants described a culture of general fear and an acceptance of casual violence within the establishments as contributing to the abuse they described. Two applicants ran away while one applicant described severe enuresis that continued into early adulthood. Applicants recounted that they did not talk about their experiences in any detail until at least fifteen years after their discharge. They felt that they would not be believed and most wanted to forget those episodes in their lives.

Period 3: 1976 - 1995

Introduction

272 This section of the chapter covers the experiences of 103 applicants (69 males, 34 females) who were placed in 47 designated establishments during Period 3 (1976-1995). Five female applicants and eight male applicants did not disclose neglect or abuse in relation to their placement during this period. However, four of these five female applicants made allegations of abuse within an establishment covered in the previous Period 2 (1956-1975) as did all of the eight male applicants. One female applicant did not make any complaint of neglect or abuse about her time in residential care. The remaining 90 applicants (61 males, 29 females) disclosed at least one type of abuse within at least one of the establishments in which they were resident.

273 Most of the abuse that was reported to the Forum was alleged to have occurred in five establishments as follows:

- one establishment was the focus of complaints of abuse from fourteen applicants
- one establishment was the focus of complaints from thirteen applicants
- one establishment was the focus of complaints from nine applicants.
- two establishments were each the focus of complaints from eight applicants.

274 There were more than four times as many male applicants as female applicants who had been in juvenile justice establishments. Both male and female applicants made a substantial number of disclosures of emotional, physical and sexual abuse.

275 It should be noted that, when compared with Periods 1 and 2, a significantly higher proportion of applicants in Period 3 had multiple placements in care. Some applicants recalled in detail the number and sequence of their placements, others were less sure. On the basis of the information provided to the Forum, it is evident that of the 90 applicants in this period who spoke about their abuse, at least 37 had already been in care in the previous period. Furthermore, at least 32 of the applicants had been in two or more placements in Period 3, some in two establishments of the same type and some in establishments of different types.

Voluntary Establishments

276 This section of the report focuses on the allegations made by applicants regarding each of the four types of abuse. Comments made by the applicants and quotations drawn from their accounts of their experiences are included.

Males: Voluntary Provision

277 Twenty-five male applicants who had been placed in nine voluntary establishments made 28 reports of abuse in these establishments. In most cases, each report related to more than one episode or instance of the abuse that was alleged. The combinations of types of abuse reported by the applicants are summarised in the following table.

Abuse types	Male	Establishments
Physical, sexual, emotional and neglect	3	2
Physical, emotional and neglect	2	2
Physical, emotional and sexual	4	2
Physical, sexual and neglect	-	-
Physical and neglect	-	-
Physical and emotional	3	2
Physical and sexual	6	1
Emotional and sexual	2	2
Emotional and neglect	1	1
Emotional, neglect and sexual	1	1
Emotional	1	1
Sexual	3	2
Physical	1	1
Neglect	1	1
Total	**28 reports**	**9 different establishments**

Note: One establishment was the focus of thirteen complaints. Another establishment was the focus of six complaints.

There were nineteen complaints of physical abuse, sixteen complaints of emotional abuse, nineteen complaints of sexual abuse and eight complaints of neglect.

Physical Abuse

278 Nineteen applicants made allegations of physical abuse inflicted on them by staff and residents in the establishments in which they were placed. They described assaults involving the use of canes, sticks, a tree branch, a fishing rod tip, rope, leather straps, a walking stick, chisels and a mallet. Applicants also alleged they were forced to stand or kneel for long periods of time, forced to eat, placed in solitary confinement such as being locked in a cupboard, deprived of food or sleep and made to take showers with the water described as too hot or too cold. The allegations of physical assaults by applicants included being punched, kicked, slapped, lifted by the locks of their hair, nipped, knuckled and grabbed by the throat.

279 The following are examples of the physically abusive incidents they complained about.

- On the day of admission, an applicant was beaten by a staff member who punched him and nipped his upper arm because he was crying. He explained to the Forum that he was upset at the time because of being separated from his siblings.
- A woodwork teacher working in a large establishment would punish the boys by placing them in a semicircle and if anyone was caught talking, he would twist the little finger of the boy, twist his arm back and proceed to kick him with excessive force on the back of his legs or on the buttocks. This teacher was also alleged to have thrown blackboard dusters and mallets at the boys, sometimes at random, and was said to be able to hit a "target" with remarkable accuracy.

280 Applicants said that assaults were frequent and injuries resulted, including bruising. Some applicants said that the staff who assaulted them became more violent when intoxicated. Others had concluded that the physical abuse was part of a control mechanism to make them more compliant for sexual abuse. One applicant described an incident in which he had jumped out of a window at night to escape and he was caught and pulled back in by a member of staff who kept hitting him on the back of his legs all the way up stairs. He told the Forum "It felt like my insides were coming out when he hit me." Another applicant said that he was punched so hard by a member of staff that the force lifted him off his feet.

281 Some applicants spoke of being beaten with a leather strap, with one commenting that he was made to strip from the waist down and the belt would hit him on the buttocks and thighs. Another applicant alleged that he was subjected to relentless beatings from one particular member of staff each time he returned late to his room. He was often late because he was being sexually abused on a recurring basis by a member of staff in another part of the establishment. This applicant told the Forum that he was unable to tell anyone about the abuse and he considered that the beatings he received were more harmful than the sexual abuse.

282 One of the applicants said that the residents in a large establishment were force-fed and if they resisted or refused to eat the food, they were beaten. Applicants spoke of care staff lifting them off the ground by their hair. One member of staff was said to have worn large rings and an applicant reported that, during bath time, she would leave marks on the boys as she forced the ring into their shoulders when holding them down in the water. Applicants described being knuckled by a member of staff. This was explained as the hand formed into a fist with the knuckle of the middle finger protruding more than the other knuckles and a flicking type action used against the child's head.

Physical Abuse by Older Boys

283 Several applicants made reference to physical abuse by other residents with one commenting that frequently older boys would come into the younger boys' room, rough them up, beat them and place blankets over their heads as if to smother them. These applicants said that staff would deliberately turn a blind eye to the bullying by the older boys and some felt there was no point in telling staff as they already knew what was going on and did nothing to prevent this or protect the younger boys.

Sexual Abuse

284 Nineteen applicants recounted sexual abuse, which involved grooming, indecent assaults consisting of inappropriate fondling, masturbation by the abuser, masturbation of the abuser by the child, oral genital contact, and anal rape. Allegations were also made of coercive peer abuse and witnessing the sexual abuse of other residents. A summary of the types of sexual abuse reported is given in the table below.

Types of Sexual Abuse	Reports*	Establishments
Inappropriate fondling	9	3
Anal rape	10	4
Oral/genital contact	6	1
Masturbation of the child by the alleged abuser	3	1
Masturbation of the alleged abuser by the child	2	1
Indecent exposure	1	1
Coercive peer abuse	2	1
Witnessing abuse	2	2
Use of violence	3	3
Grooming	2	2
Other eg being photographed inappropriately	8	3

***Note:** 'Reports' relates to the number of references to types of sexual abuse made by applicants during their meetings with the Forum rather than to the number of individual instances of each type of abuse which, for some applicants, allegedly occurred over several years.

285 One of the applicants recalled that on the day of his admission to an establishment, he was told by a member of staff that he had to have a medical examination. The member of staff took him to the games room and instructed him to remove his clothing. He then checked him for rashes and fondled his genitals. Following this incident, the staff member continued to behave in an inappropriate manner and would make contact with him as if to play but, the applicant concluded, this was simply a means to allow him to touch him inappropriately. This same staff member was said to watch him and the other boys when they were getting showered and "look them up and down." Another applicant made allegations of being fondled inappropriately by a staff member on the pretext that he was applying a medical treatment. A similar situation was disclosed by an applicant who said that he had been called to the office of a senior member of staff who told him that he had to check if he had been abused and then proceeded to fondle him.

286 Many applicants who had been sexually abused recounted that the sexual abuse progressed over a period of time from inappropriate fondling to masturbation, oral genital contact and then, for some, to anal rape. Applicants alleged that, at times, sexual abuse was accompanied by force; for example, one applicant said the alleged perpetrator placed his hand over his mouth whilst he was indecently assaulting him.

287 An applicant who described being forced to masturbate a member of staff said that he and his twin brother went on to suffer extreme sexual abuse including anal rape by a number of staff throughout their placement in a voluntary establishment. He told the Forum that:

> "With the rapes, you get to a point where you turn off, lie down and just let them get on with it. Any brother who wanted to abuse us did. The others turned a blind eye and didn't say anything."

288 Several other applicants made allegations of anal rape. One applicant described being put in a single bedroom when other residents were on home leave. He said that a brother came in to pray with him but hit him on the knee, pulled all his clothes off and raped him. The brother then took the clothes away and the applicant had to go down to breakfast the next morning wrapped in a blanket. The applicant said that he thought the brother had washed his clothes, dried them and returned them to his locker. The sexual abuse disclosed by a number of male applicants who had been placed in the same establishment was described as constant and occurred without any form of grooming. One applicant commented that inappropriate behaviour was seen as a right to which the abusers were entitled.

289 An applicant alleged that a professional photographer, who had been brought to the establishment to take photographs, gained access to the showers when a staff member was seeing to the needs of other boys. The photographer invited those who were in the shower area to take their clothes off and pose together. The male resident became upset and told the member of staff who ordered the photographer off the premises.

Sexual Abuse by Older Residents

290 Some applicants spoke of being raped anally by older residents. One said that when he was around five years old he shared a bedroom with his older brother and that both of them were timid and subjected to constant bullying. This applicant said he woke up to see his brother being held down and raped.

291 An applicant told the Forum that he was sexually abused when he was seven or eight years of age. He said that he was physically held face down by a group of older male residents and seriously sexually abused. Although he was asked at the time if he had been abused, he did not disclose the details of the incident until he was around thirteen years of age. He attributes his anger and rebellion in his teens to the abuse he suffered as a young child.

Emotional Abuse

292 Sixteen male applicants described a number of forms of emotional abuse. These included personal emotional abuse, family denigration and links discouraged, being shown no affection, bullying by older residents and exposure to fearful situations. They said this abuse undermined their self esteem and emotional wellbeing. These forms of emotional abuse are the subject of the following paragraphs.

Personal Emotional Abuse

293 Some applicants commented that they had no privacy when using the bathroom and staff watched them. They said that staff referred to them by derogatory names such as "scum from Belfast." Several applicants recounted that on admission to the establishment, they were immediately stripped, bathed, and their hair was shaved.

294 An applicant described himself as an already traumatised child when he was placed in care because of the violence in his family home. He said that when he was in the establishment, he wet the bed and, as a punishment, was beaten by staff. Following this, his bed-wetting worsened and he spoke of washing the wet sheets in the bath and drying them on the radiator as he was terrified of the consequences of staff knowing that he was still wetting the bed. Some male applicants described insensitive treatment, for example, several said they were at times made to wear girls' clothing, were bathed with girls, and had to endure other children urinating when they were sharing the bath.

Family Denigration and/or Links Discouraged

295 Some applicants recounted the sadness they experienced due to the limited, or lack of, contact with family members, particularly parents and siblings, when in establishments. They expressed concern that contact with their family was deliberately frustrated by some of the staff. One applicant recalled that his father was made to feel unwelcome when he visited him in the establishment and another said that his mother wrote letters to him but he never received them.

296 Applicants described the difficulties they experienced when they were separated from their siblings, even when they were placed within the same establishment. One applicant recounted that he was not allowed to keep in touch with two of his siblings with whom he was very close and referred to the pain this caused him. Another applicant explained that he was initially in the same bedroom as his brothers but they were all separated with no explanation and the impact on him was significant, leaving him feeling bereft every night. An applicant spoke of the pain of being separated from his brother and running away from the establishment specifically to see him. Some applicants who had been placed in voluntary establishments described being belittled by staff and the feeling of shame that followed.

297 Applicants who were placed in a church-run establishment said the following:

> "We were told we were all sinners, not told anything. If we asked questions we were told to shut up."
>
> "We were bathed in very hot baths and scrubbed with a scrubbing brush…A member of staff told us 'I am scrubbing away your sins'."

298 An applicant spoke about a teaching assistant mocking him for scrunching up his face and squinting at the blackboard because he couldn't see the blackboard very well. Other applicants who had great difficulty eating certain types of food spoke of the humiliation of being made to eat regurgitated food.

Deprivation of Affection

299 Several male applicants spoke of living in establishments that were devoid of emotional warmth and affection. They described the settings as uncaring and, as one applicant said:

"there was never a kind word, you were either ignored or beaten."

Other applicants spoke of witnessing their peers being admonished and several commented that seeing the humiliation of others was sometimes as traumatic as being on the receiving end of the abuse.

300 The removal of personal belongings, such as toys, was referred to by several applicants. One applicant said that on admission personal possessions were removed by staff and he remembered being told: "no toys here." An applicant, in reflecting on his time in residential care, said "No one cared for you," and "I had no mentor."

Exposure to Fearful Situations

301 One applicant recounted the fear he felt as he heard the belt being used on other residents and hearing them whimpering with the pain. One applicant described being constantly worried that he would be beaten again and referred to being "*terrified*" and "*hating*" the establishment because of the cruelty of two of the staff members. This applicant also said that another member of staff had a very sharp tongue and was dismissive and cruel to him. Incidents recounted by applicants included witnessing the drowning of kittens that they and other residents had befriended. An applicant told of being taken to an area of Belfast by his social worker where he felt intimidated by the locals.

Neglect

302 Neglect was mentioned by eight applicants, a smaller proportion of applicants than had been the case in the two earlier Periods, with few commenting on aspects of care. A male applicant described his establishment as a "cold draughty place, with wind whistling through the corridors, and poor lighting". He said that the blankets on the beds were army style and very rough, causing him itching. Another applicant said that the staff in his establishment expected the children to be very quiet: "we were not allowed to be spontaneous and play outside was very rarely allowed." A few applicants recounted being made to eat porridge. If they refused, they were forced to swallow it, even if this resulted in the food being regurgitated. In another establishment, an applicant said that he had been a slow eater and, on occasions, food was removed from the table before he had finished. Several applicants commented that their childhood experiences in relation to certain food types have affected their taste for those foods in adulthood.

303 Some applicants expressed concerns about a lack of medical care. One commented that he was not provided with medical attention when he injured his ankle jumping from a window. Another applicant who had an ongoing serious medical issue with his kidneys said he was neglected when he was unwell and recounted one occasion when he was taken to hospital by a member of staff who told him that he was dying and then left.

304 Some applicants referred to the lack of supervision in their establishments. One alleged that there was no staff supervision at night, which allowed older boys to come into the rooms of younger boys where, the applicants alleged, they bullied and sexually abused them at will. An applicant spoke about frequent fights between the boys, commenting:

> "you were either being beaten by other boys or you were beating someone else."

He and others questioned the adequacy and effectiveness of the staff's supervision and protection of the children.

Knowledge of Abuse and Disclosing Abuse at the Time

305 Applicants told the Forum that other residents and staff witnessed much of the abuse in the establishments. In addition to their fellow residents, who witnessed and experienced similar abuse, they said that care staff, ancillary workers and teachers were also present when different instances of abuse occurred. Applicants explained that many residents were intimidated by the threat of violence and would not report what they had seen. Some said that most residents knew from personal experience the severity of the treatment given to those who complained. Several applicants reflected that there was no one to tell without fear of compromise. A number of applicants, who said they tried to report what was happening to them, felt they were not believed. The comment "What was the point of telling anybody?" expressed fully the view they shared.

Methods of Coping with Abuse and Strategies used by Alleged Abusers

306 The male applicants described a number of ways in which they responded to their alleged abuse. They spoke of running away, sometimes repeatedly to the point where they were placed in more secure accommodation. Others, who said they were constantly frightened, accepted the abuse as inevitable. They tried to block it out and some withdrew into themselves. The means by which compliance was achieved are evident in earlier descriptions of abuse in this chapter and included the exercise of authority by the adults who were meant to be caring for them, the use of violence against them and the general atmosphere of fear that pervaded their establishments.

Females: Voluntary Provision

307 Thirteen female applicants who had been cared for in eight voluntary establishments in Period 3 made allegations of abuse. There were eight complaints of emotional abuse, eight complaints of physical abuse, four complaints of neglect and four complaints of sexual abuse. The combinations of abuse types said to have been experienced by these applicants are summarised below.

Abuse types	Females	Establishments
Physical, sexual, emotional and neglect	1	1
Physical, emotional and neglect	-	-
Physical, emotional and sexual	1	1
Physical, sexual and neglect	-	-
Physical and neglect	1	1
Physical and emotional	2	1
Physical and sexual	1	1
Emotional and sexual	-	-
Emotional, neglect and sexual	-	-
Emotional and neglect	2	2
Emotional	2	2
Sexual	1	1
Physical	2	2
Neglect	-	-
Total	**13 reports**	**8 different establishments**

Note: One establishment was the focus of six complaints. Another establishment was the focus of two complaints.

Physical Abuse

308 Eight female applicants disclosed physical abuse, including smacking, being dragged by the hair, having finger nails dug into them and being kicked. Few mentioned the use of belts or canes. Bullying was mentioned frequently.

Descriptions of Physical Abuse

309 An applicant said that a member of staff who was "very strict but generally ok smacked me on the face and head". Another applicant referred to being "hammered (by a particular member of staff) for anything and everything – even for moving your seat in the living room", but commented that "these beatings stopped after a change in the law," in the early/mid 1980s. One applicant said that a senior member of staff was very physical in manner and picked on her. This applicant said:

> "I was dragged by my hair, slapped, pushed against a wall; she would dig her nails into me, kick me; she trailed me across two beds by my hair. I was pinned down on the floor by three adults sitting on top of me on her say so and locked in a room on my own for days in the dark."

310 Applicants spoke of being bullied by other residents and of how difficult this was for them. One applicant who expressed her concerns about this also questioned the lack of action by staff to stop it. She recalled an incident when she had the courage to report the bullying and asked staff "Why do people keep picking on me?" But nothing changed and the bullying continued. This applicant also told of being slapped around the face and grabbed by two members of staff who told her "Don't dare tell your mum".

311 Several applicants spoke of solitary confinement as a punishment. One said that she was often locked in a room as a punishment. Another described being placed in a room on her own in an area of the establishment that was used once a week. These applicants explained that a resident could be left there for "days on end" and described being terrified when the lights were turned off.

Sexual Abuse

312 Female applicants made few allegations of sexual abuse. The four who did, spoke of inappropriate fondling and coercive peer abuse. One applicant described being brought by a member of staff to a room and left alone with a visiting priest who would put her on his knee and put his hand up her skirt. This applicant said she has very clear memories of these incidents but does not know how many times this happened. Another applicant said that on one occasion, when she was aged approximately ten years old, a male resident took her to a secluded area beyond the orchard and tried to involve her in oral sex.

Emotional Abuse

313 Eight applicants made reference to emotional abuse they said they experienced in voluntary establishments. The following aspects of emotional abuse were evident in their accounts.

Personal Emotional Abuse

314 Some female applicants spoke of the public humiliation and personal denigration they experienced. Some of the emotional abuse described by the female applicants was rooted in sectarian attitudes. One applicant spoke about staff pouring de-lousing liquid over her hair and being accused of bringing lice into the home. She said the liquid treatment had to remain in her hair for most of the day and she was subject to other children mocking her and a member of staff commenting, "I've seen the state of your home" and "Protestants are not bothered by lice."

315 In referring to their admission to an establishment, some female applicants said their personal belongings had been removed, including their clothes, and they were given "hand-me-downs" to wear. These applicants questioned where their personal possessions went, as many were not seen again.

Family Denigration and/or Links Discouraged

316 Several female applicants said that some staff would make offensive comments about their families and this denigration was very painful. One applicant said that she was referred to as a "bastard" by staff as her mother was unmarried. Another female applicant said that her father was criticised by the nuns as he was Protestant. Her mother was also criticised because she was not married and in a relationship with a Protestant. This applicant said that at her Confirmation, the nun in charge was critical of her father for his choice of her Confirmation name, commenting "What would he know? Your Confirmation is a mockery."

317 Referring to the lack of contact with siblings, one female applicant said that she saw her brother, who was in foster care, on one occasion only. She said "this should not have been allowed to happen."

Deprivation of Affection

318 Other applicants emphasised the lack of affection they were shown whilst in their residential placements. One said that, during her time in the establishment, she was not shown any warmth or encouragement and believes that her education and social development suffered as a consequence. Another applicant said that no one took an interest in the residents and the culture of the establishment failed to nurture the children. An applicant said that during her time in an establishment:

> "the staff never asked if I was okay and this lack of action and lack of knowledge was a form of neglect."

Bullying

319 Some female applicants made reference to bullying by staff and other residents. There were further allegations that some staff colluded with the perpetrators as they did not challenge these inappropriate behaviours. One applicant explained that she made a complaint to staff about bullying by older residents but they failed to act and did nothing to prevent this from re-occurring. Another applicant described an incident in which a boy pulled her hair and she told staff but, she said, the staff encouraged other boys to behave in this inappropriate way also.

Neglect

320 Four female applicants made allegations of neglect in respect of several aspects of their care. One said that when she was a child she was a bed-wetter and was often left to lie on wet sheets. Another said that there was an absence of toys and games for the children and they were under-stimulated in their developmental years. One applicant said that no time was allowed for play. Another applicant told the Forum she was made to do inappropriate and continuous work. This applicant listed the work she had to do before and after school, included feeding and dressing the younger children, changing and washing wet sheets and cleaning the floors and the toilets.

Inadequate Medical Care

321 An applicant recalled having a severe toothache when taken with other residents for a fortnight's holiday to a seaside resort. When she informed the staff of her toothache, she was accused of telling lies. Another staff member eventually gave her a painkiller and instructed her to go to bed. The staff then went out for the day with the residents while she was left in her room with no adult support or supervision.

Lack of Staff Supervision

322 A number of female applicants identified lack of staff supervision as a deficiency in their care in voluntary establishments. One of them, who had sustained burns to her neck and torso as an infant when in the care of a voluntary establishment, told the Forum that a staff member had left her unattended on a counter top and she had picked up a kettle and scalded herself with boiling water. Another applicant remembered the children being out of control in her establishment and described the scene as a "riot" with young children smashing the window with their bare feet and staff failing to intervene. A third applicant said that she was a persistent absconder when in care and was constantly truanting from school but staff did not appear to be interested in finding the cause of her behaviour or question where she had been.

Methods of Coping and Strategies used by Alleged Abusers

323 Female applicants, in describing their responses to alleged abuse, spoke of feelings and behaviour similar to those of the male applicants who had been in voluntary establishments. Their comments were expressed with anger, resignation and frustration. They spoke of crying, fighting back, trying to run away, blocking the abuse out and keeping their feelings to

themselves. They too had been controlled by members of staff using their authority inappropriately, by physical violence and by threats that left them intimidated and insecure. They had no confidence in reporting what they were experiencing.

Males: State Provision

324 Fourteen male applicants who had been placed in eight state establishments in Period 3 made fifteen reports of one or more types of alleged abuse. There were ten reports of emotional abuse, eleven reports of physical abuse, four reports of sexual abuse and three reports of neglect. The combinations of abuse types they alleged are set out in the table below.

Abuse types	Males	Establishments
Physical, sexual, emotional and neglect	-	-
Physical, emotional and neglect	2	2
Physical, emotional and sexual	2	2
Physical, sexual and neglect	-	-
Physical and neglect	-	-
Physical and emotional	5	2
Physical and sexual	-	-
Emotional and sexual	-	-
Emotional, neglect and sexual	-	-
Emotional and neglect	-	-
Emotional	1	1
Sexual	2	2
Physical	2	2
Neglect	1	1
Total	**15 reports**	**8 different establishments**

Note: One establishment was the focus of eight complaints.

Physical Abuse

325 Inappropriate physical behaviour resulting in physical harm was mentioned by eleven applicants who spoke of being bullied and beaten by other residents and physically assaulted by members of staff. Some applicants said they were punched, kicked, had their hair pulled and were slapped. The following instances of abuse were mentioned by applicants:

> "I lost a tooth as the result of a punch by a member of staff, and the dentist I was taken to see colluded with the member of staff in not reporting the assault."
>
> "I lost count of how many times I was beaten. Your man got tore into me."
>
> "I was pulled from a chair by my ears, slapped and kicked, and a member of staff stamped on my hand fracturing my fingers. I remember being spun off a carousel so fast that I landed on the ground and fractured my wrist."

326 One applicant who had run away from his establishment, was taken on his return to a room, stripped naked and beaten from head to toe by a staff member using the palm of his hand. The beating resulted in red marks all over his body. Another applicant who had run away was strapped to a bed when he returned and was given an injection. Being placed in a form of solitary confinement was mentioned by male applicants, as was being forced to eat. An applicant said the residents in his establishment were forced to eat food they did not like and that members of staff would hold his head firmly whilst he made him do this.

Sexual Abuse

327 Four male applicants disclosed sexual abuse by staff and other residents on a spectrum from grooming, through inappropriate fondling to anal rape. One applicant who was indecently assaulted and made to masturbate his abuser as well commented "You are at your most vulnerable when you feel unwanted." One of the applicants who disclosed that he had been seriously sexually assaulted on a number of occasions by male and female staff explained that "There were no locks on bathrooms; staff could come in on young people." Another applicant talked of being taken out in a car with a male care worker and being bought a Chinese meal. This man who, he said, smelt of stale drink and smoke, started to sexually abuse him during this trip. The applicant was too upset to elaborate any further.

Emotional Abuse

328 Ten applicants provided a number of examples of emotional abuse which they said undermined their self esteem and emotional well-being. One applicant referred to a specific event when he was made to go to an Orange parade despite objecting and being terrified of going. Another applicant felt humiliated by a member of staff who kept making inappropriate comments in relation to his eye calling him "lazy eye". Another applicant was not allowed to use the bathroom and as a consequence wet the bed. Staff referred to him as a "dirty little bastard." Another applicant spoke of a female member of staff continuously trying to "push the Bible down my throat."

329 One applicant said that he was told on numerous occasions by staff members that his mother did not want him. Other applicants considered that the environment in which they were resident was not conducive to a child's emotional wellbeing as it was one of fear, and devoid of warmth and affection.

Neglect

330 Male applicants in state sector establishments made few allegations of neglect. Of the three who did report neglect, all spoke of establishments having a lack of play opportunities and alleged inadequate medical attention and inadequate education. One applicant said that in his establishment one of the punishments used was to keep children away from school for a period of time. He said he was punished in this way repeatedly and, as a result, he was unable to read or write when he left care.

331 Another applicant, who complained of constant bullying in his establishment, said that he felt vulnerable all the time as there was no one who really cared or who tried to stop the bullying. He saw this lack of engaged supervision as neglectful.

Females: State Provision

332 Ten female applicants made twelve reports of alleged abuse in ten different state establishments. There were seven complaints of sexual abuse, ten complaints of emotional abuse, six complaints of physical abuse and two complaints of neglect. The combinations of abuse types they alleged are set out in the table below.

Abuse types	Females	Establishments
Physical, sexual, emotional and neglect	-	-
Physical, emotional and neglect	1	1
Physical, emotional and sexual	3	4
Physical, sexual and neglect	-	-
Physical and neglect	-	-
Physical and emotional	2	2
Physical and sexual	-	-
Emotional and sexual	2	2
Emotional, neglect and sexual	-	-
Emotional and neglect	-	-
Emotional	2	2
Sexual	1	1
Sexual and neglect	1	1
Physical	-	-
Neglect	-	-
Total	**12 reports**	**10 different establishments**

Note: Three establishments were the focus of two complaints each.

Physical Abuse

333 Six female applicants spoke of being hit, including with a slipper, and being bullied and beaten by other residents. One who said she was bullied by older residents remarked that "staff did not want to know." Another applicant described staff as very physical:

> "They would grab you by the arms, or by the scruff of your neck; they were really rough, and would throw you down, or you might be dragged and then thrown into a room. I was in the same room as my brother

who had behavioural problems and who was very violent – sometimes he had to be restrained in a jacket – I did not feel protected from him."

Whilst in that placement, this applicant said she was subjected to a physical restraint for the first time and found this to be a painful experience, emotionally and physically. She said that the restraints became more excessive in frequency and degree and alleged that a particular staff member would dig her nails into her. This applicant recounted being restrained on a staircase and her trousers being pulled down and her top pulled up, exposing the private areas of her body, which she found very upsetting. To this day she does not like to be touched.

Sexual Abuse

334 Ten female applicants who had been placed in state establishments made allegations of rape and indecent assault perpetrated by male residents and staff. One applicant referred to an older male resident roaming through the bedrooms at night and indecently assaulting the female residents. Another applicant spoke of being taken in her night dress by a member of staff to see someone introduced to her as a "doctor" who indecently assaulted her. An applicant said she was abused by a female care worker who indecently assaulted her by fondling her breasts, kissing her, and involving her in other sexual activity.

Witnessing Abuse

335 An applicant who recounted witnessing abuse said she saw a vulnerable resident being sexually abused by two male residents on the floor of a bedroom. On another occasion, this resident was said to be with an older man who had apparently groomed her with the offer of cigarettes. The applicant commented that the "staff did not seem to care."

Emotional Abuse

336 Seven female applicants spoke of experiencing emotional abuse in their establishments.

Personal Emotional Abuse

337 A number of applicants spoke of public humiliation and personal denigration. An applicant said that the children were described by staff as "a bunch of wee bastards." Another, who regularly wet her bed, explained that the staff became fed up changing it and refused to change the sheets or give her clean underwear. She said she was washed in a cold bath

with disinfectant, was scrubbed until her skin was "red raw" and often ended up sleeping on the floor. One applicant spoke of the humiliation experienced when made to have a bath while staff, including male staff, observed. One applicant asked staff if it would be possible for her to have a new pair of trainers. In front of everyone, staff told her she didn't have any when she came into the establishment and that she wouldn't be getting any whilst she was there.

Family Denigration and/or Links Discouraged

338 Emotional abuse related to their families was mentioned by a number of female applicants. This included family denigration, family being forbidden or discouraged to visit, and family or sibling links being discouraged or forbidden. One applicant explained that her mother was said, by staff, to be "only looking for food" when she came to visit, but when her mother said she wouldn't come back, the staff blamed the applicant. Another applicant's mother was said to have been discouraged from visiting because of the negative comments made by the staff.

339 Applicants said that not seeing their families or being separated from siblings was used as a threat. One applicant said she never got to see one of her siblings and another saw her siblings only once. Another explained that two of her siblings had been brought from foster care to be with her but that she was threatened by staff that they would be taken away if she didn't behave herself. An applicant was only rarely permitted to see a sibling despite her being a resident in the same establishment.

Exposure to Fearful Situations

340 This aspect of emotional abuse was highlighted by some applicants; one said: "All you could hear was kids screaming all the time" and went on to explain that whilst in the establishment she was not protected from her brother who was very violent and as a consequence often had to be restrained.

341 An applicant had asked to be taken into care and to be with her brothers and sisters in a particular establishment. However, she was taken aback by the strict regime and her first experience of restraint. She was subsequently separated from her siblings when they were sent to different homes and she was placed into foster care.

Deprivation of Affection

342 Being shown no affection was also commented on by applicants. One applicant described her establishment as:

> "A building with no feeling, a cold unfriendly and unhappy place. We were not cared for, not looked after, we were hungry, cold and sore. There was no care or kindness shown; all you could hear was kids screaming all the time."

Staff apparently denigrated one applicant and referred to her as an "odd girl" because she didn't smoke and had kept her religious faith. Another explained that when her social worker visited she often cried, but that the social worker's response was not to ask what was wrong but to just tell her she should be stronger.

343 One applicant explained that she was often placed in isolation and that a particular staff member would bully other residents and play them off against each other. This member of staff also reportedly told lies in saying that the applicant had phoned his home and "talked dirty" to him, something she strongly denied.

Neglect:

Lack of Supervision

344 Two female applicants spoke of a lack of supervision in their establishments in the state sector. One explained that in her establishment at night there appeared to be no night staff available or willing to stop a male resident attempting to molest them whilst they slept. Another described how the manager was often intoxicated whilst in charge of the children.

Aspects of Care

345 Poor hygiene, inadequate bedding, food and heating were also mentioned in relation to neglect. An applicant explained that she regularly wet her bed and that staff would refuse to change the sheets, which resulted in her having to sleep on the floor and wear unclean, wet underwear. When she eventually got a bath it would be in cold water with disinfectant. It was also disclosed that if they refused the food they were given they went without. Another applicant said that neglect resulted in the children being cold, hungry and sore.

Males: Juvenile Justice Provision

346 Thirty-three male applicants made thirty-nine reports of alleged abuse in six different establishments. There were 25 complaints of physical abuse, twenty complaints of emotional abuse, twenty complaints of sexual abuse and eight complaints of neglect. The combinations of types of alleged abuse are set out in the following paragraph.

Abuse types	Males	Establishments
Physical, sexual, emotional and neglect	2	2
Physical, emotional and neglect	1	1
Physical, emotional and sexual	6	3
Physical, sexual and neglect	-	-
Physical and neglect	1	1
Physical and emotional	6	5
Physical and sexual	3	2
Emotional and Sexual	1	1
Emotional, neglect and sexual	1	1
Emotional and neglect	1	1
Emotional	2	2
Sexual	7	4
Physical	6	3
Neglect	2	2
Total	**39 reports**	**6 different establishments**

Note: One establishment was the focus of fourteen complaints. Two establishments were the focus of eight complaints each.

Physical Abuse:

Inappropriate physical behaviour resulting in physical harm

347 Inappropriate physical behaviour by staff resulting in physical harm to residents featured frequently in the recollections of the applicants who had placements in juvenile justice establishments. Some of the physical abuse reported was said to have involved the use of a range of objects and implements, for example, leather straps, canes, sticks and bunches of keys were mentioned by several applicants. The most common form

of physical abuse referred to by applicants included punching, kicking and slapping.

348 An applicant who had run away with two residents from an establishment told the Forum that eventually he had returned with the other boys at 3.00am. It was very cold, yet the boys were stripped and whipped by two members of the staff. One applicant described being regularly bullied, verbally abused (called a 'half breed' as he was from a mixed marriage) and regularly hit, including with a stick, by a member of staff. One day he retaliated and hit this member of staff on the side of his head with a stick. The supervisor in charge investigated the matter and pointed out to the member of staff that he had been "torturing the chap from day one" so he would report the matter and give details of all aspects of the incident to the officer in charge.

349 Being struck with wet towels and being locked in at 8.00pm, with no visits by staff members until the following morning, was mentioned by one applicant. He referred to a violent culture in the establishment, and described an initiation regime operated by other prisoners, in which they would make the newcomers "run the gauntlet" at night time, hitting them with wet towels with knots tied in them and also getting them up from bed and putting them in a blanket and throwing them up until they hit the ceiling.

350 Another applicant complained about being restrained by a member of staff who pushed his arms up his back causing excruciating pain and of being beaten with a gym slipper, which really stung. He also alleged that members of staff would come on duty intoxicated and beat the boys around the head with a telephone book. He recalled that a night watchman, of whom the boys were making fun, used a rubber torch to beat them around the room.

351 Examples of physical assaults including punching were spoken of by 25 applicants. One applicant alleged that another staff member called in the head of the unit within the establishment (who lived nearby), to deal with him in relation to a behavioural matter. The head of unit "laid into him" with fists, boots, and gripping actions and also pulled his hair. He said this happened repeatedly and that sometimes he curled up and took it, but sometimes he retaliated.

352 An applicant said that he was subject, as he alleges were other boys, to a regime of being slapped by staff and in one instance being assaulted

by a PE instructor. This regime of ongoing, often severe, physical abuse affected him deeply; as he put it "the slaps were too much for young lads." The PE instructor beat him up when he was caught smoking and kicked him in the mouth, leaving his lip bleeding.

353 One applicant described his establishment as being like a concentration camp with a very strict regime where you were "tortured" for infringing any of the rules regarding behaviour in the cell, for example, sitting on the bed during the day or leaving marks on cleaned surfaces. Assaults included slaps, punches to the head and body, being kicked and being hit in the face with a bucket. Most assaults were by staff using their hands. He told the Forum that when approached by a member of staff:

> "you had to immediately stand up and give your prison number, name, Sir, twelve calendar months; if you were too slow you would be assaulted."

354 Another applicant spoke of constant daily beatings, being bruised frequently and described a very punitive coercive regime with no merit in it; he said that hearing and seeing other young people beaten was for him even worse than his own mistreatment. He appears to have been put into solitary confinement with a bed and Bible but it was unclear how long he was kept there. On another occasion he described being held down, stripped, beaten and kicked in the stomach by a female member of staff.

355 As part of the initiation process described by one applicant, a member of staff who was known by a nickname would say "I'm animal (name), don't fuck with me" and he proceeded to punch the boys in the head. Following this, he left the boys alone. It was common to have the other boys beat new entrants and see other boys being abused. He was also made to play a game without rules called "murder ball" in which the boys would punch and beat one another. He felt it was like a blood sport for the prison officers to watch.

356 Boys were expected to keep their cells spotless. An applicant explained that as he was locked up for so many hours per day, his cell remained spotless. One member of staff inspected the cell thoroughly but another member of staff accompanying him lifted the plastic chair and placed his finger inside the tubular legs and found a speck of dust. He punched him in the face and called him a "dirty bastard." The member of staff who accompanied this man looked embarrassed and returned later to give the applicant a half ounce of tobacco. On another occasion, the nurse gave

him green liquid to drink which he thought to be a sedative. He was then taken by six members of staff to another part of the prison and beaten badly: his skin was gouged, he had marks everywhere and his teeth went through his lip.

357 An applicant told the Forum that after a disagreement with another resident, he was asked by staff to go to a room. He refused and when he was held by his arms he struggled; another member of staff was called who then punched him very hard in the small of his back (he said that it felt like being hit with a baseball bat), knocked him to the floor and knelt on him.

358 It was reported that a member of staff in another establishment punched an applicant in the stomach when he tried to tell him about the sexual and physical abuse he was experiencing. Some applicants spoke of forms of solitary confinement. For example, an applicant said that on at least one occasion he was locked in his dormitory. Another applicant described a cell block with three cells and a yard where boys could be kept for lengthy periods.

359 A punishment for running away was described by an applicant who talked of being made to have a cold shower and being beaten with a blackthorn stick by the watchman. He said that he was made to stand in cold showers and also in wet clothing as a punishment for absconding. Another applicant described a similar punishment of being put outside in the cold or given cold showers if the residents misbehaved.

Bullying

360 Some applicants described occasions where they had been bullied or beaten by other residents and one of them explained that sometimes staff would get other residents to beat him.

> "Staff treated you like dirt; if they didn't hit you they would get other men or boys to do it."

Some applicants said that in their establishments this type of behaviour was permitted as part of the system.

361 A regular occurrence described by one applicant was for the residents, the applicant included, to be put into a makeshift boxing ring with other boys and made to fight for one minute. He described this as very frightening.

362 One applicant, who referred to some of the members of staff being very violent, was also very keen to say that some other members of staff were kind.

Sexual Abuse

363 Twenty male applicants disclosed incidents of sexual abuse, ranging from indecent assaults to anal rape, whilst resident in juvenile justice establishments.

Indecent Assaults including Inappropriate Fondling

364 Indecent assaults including inappropriate fondling were mentioned by several applicants. One applicant explained that a member of staff came into his room and put comics on his bed and then proceeded to put his hand under the comics and "touch him up" whilst making rasping noises and saying "you're a good boy" before leaving the room. As a result of this, the applicant explained that he used to put his wardrobe up against the door to prevent the member of staff coming in. On one occasion all the boys in his dormitory were told to put on their dressing gowns and come downstairs to watch TV; the member of staff tried to entice him out of the room but he resisted. Another applicant said that members of staff touched him on his "privates" each time he showered.

365 An applicant explained that a number of boys were resident in single bedrooms off a long corridor. He said that a member of staff would wake him in the morning by shaking him with his hand on his body whilst he was lying in bed. The member of staff would touch him in the area of his genitals, starting on top of the bed clothes but then progressing to moving his hand under the bedclothes and touching his penis. Several different members of staff would wake him in this way and started visiting him in the night when they would masturbate him and make him masturbate them. This, he disclosed, progressed to anal rape.

366 An applicant who was in bed in the dormitory, was approached by the night watchman who touched him inappropriately. Another applicant said that he had to take washing once a week to the laundry. In the laundry a member of staff would put his hands around him and he said that he could feel that he had an erection. The member of staff would also put him over the machines in the laundry and simulate sex.

367 On his reception into one establishment, an applicant said that he was instructed by two members of staff to strip and shower. He was very

frightened and referred to himself as being small in stature and terrified of these two members of staff. He went on to explain that he was then touched inappropriately and sexually abused by one of the members of staff.

368 Some applicants described being made to masturbate members of staff. On occasions this was accompanied by veiled threats, for example, a member of staff told one applicant that although he had been sentenced to spend between one to three years in the establishment "we could make this three or six months" which he understood to mean that if he cooperated with the sexual abuse, then leniency would be shown. This particular applicant felt unable to go into detail but did say that speaking to the Forum was the first time he had felt able to talk of the sexual abuse he had experienced. He said this included being sexually abused by a number of staff, including one occasion when he was brought to a store room and the abuse began with rubbing and progressed to his being made to masturbate the member of staff.

369 Another applicant described being asleep in the dormitory and being wakened around 2.00am by someone (who he subsequently discovered was another resident) lying under his sheets giving him oral sex. When the applicant realised what was happening, he ran into toilets where he came across a member of staff who asked him why he was there. Instead of helping him, the member of staff pushed up against him, fondling him. He was shocked, and could not believe what had happened so he got up early and reported it to a senior member of staff who told him:

> "Don't be awkward – if you make false allegations then things will get bad for you."

Coercive Peer Abuse

370 Coercive peer abuse was mentioned by an applicant who talked of being moved from a single room to an eight person dormitory, which he was told by another resident was referred to as "the cock suckers dormitory." Whilst in this dormitory, he explained that an older resident who was a bully would make another boy go and "suck the cock" of anyone he nominated. The second night he was in the dormitory he was nominated so he threw a table through the window and ran away.

Anal Rape

371 Some applicants disclosed incidents of anal rape. One of these explained that when he arrived at the establishment from a police station,

accompanied by members of staff, he was taken in by the side door of a particular section, separated from his co-detainee and taken into a bungalow next door. Once inside, he said that he was held down by two members of staff and raped by a third.

372 One applicant said that he was groomed by a member of staff who had told him that he was not wanted by his mother or father. He said that he felt very vulnerable when he entered the establishment but responded positively to the new environment. The member of staff was kind to him initially but started to groom him and proceeded to touch him inappropriately and moved on from that to anal rape.

Other Forms of Sexual Abuse

373 Other forms of sexual abuse were also mentioned by applicants. One explained that none of the boys would use the showers as the members of staff would watch them in the shower. He used the shower on his first day as no one had told him about this but when they did, he no longer used them. Another spoke of members of staff masturbating in front of the boys.

Emotional Abuse

374 Twenty applicants spoke of a number of forms of emotional abuse that they considered undermined their self esteem and emotional wellbeing.

Personal Emotional Abuse

375 The following are some examples of the abuse applicants alleged.

- One applicant said that he remembered being humiliated when his father came to visit him. Unlike all the other boys who wore their normal clothes, he was made to wear his pyjamas. He asked why this was the case and was told by a staff member "Because you have to earn it" (ie the privilege of wearing ordinary clothes).
- Another applicant spoke of an occasion when he was stripped and made to stand naked in the staff common room for two hours – this was apparently intended to stop him running away. He didn't believe there was any sexual element to this punishment but explained that other staff members were present during this period. He described his overall treatment as "being treated like dirt."
- One applicant felt humiliated on one occasion when in the dining area with a large number of boys present, he was told by a member of staff that he was "going to be a borstal failure."

- An applicant commented that it was the norm to be referred to as "scum" and as "a borstal failure." Another said that he was repeatedly told by a certain member of staff that his mother put him into that particular establishment and she didn't want him. He was told by staff from his admission up to discharge that "You have no mother or father - we are your mother and father - you are number xxx". He felt dehumanised by this behaviour.

376 Some applicants believed that there was a sectarian bias in the emotional abuse they experienced. One applicant described feeling intimidated by staff and older boys as he was a Catholic in an establishment staffed by members of another denomination. Another recalled being called sectarian names such as "Fenian bastard" by staff members – for example, when one of the boys cheered after it was reported that a bomb had killed a number of soldiers. Yet another applicant disclosed that he had been told that he was worthless and would spend his life in prison. This was accompanied by constant sectarian taunts from the staff members.

377 One applicant, whose brother had been a member of the INLA and had been shot dead, had 'INLA' tattooed on his fingers in memory of his brother. He explained that he didn't fully appreciate the full significance of it or the ideology behind it because of his age. He felt that the staff picked on him and singled him out because of this and many of them would make comments in relation to or linked with the tattoo. For example, a member of staff said he would like to cut his fingers off.

378 Another applicant spoke of a sexual basis to the emotional abuse, explaining that a member of staff would often make derogatory remarks to him such as "I would like to make you up like a lady boy; you're eye candy." This he considered was very degrading, but he felt powerless to know how to manage the constant innuendoes and sexual references made about him in the presence of others.

Deprivation of Affection

379 Being shown no affection whilst a resident in an establishment was referred to by some applicants. For example, one considered that he had been placed by the state in an environment that left him exposed to violence, bullying, recruitment into paramilitarism and general criminality. He referred to the establishment being "a war zone" in which he had to become hyper vigilant to survive. Another simply expressed the view that no warmth was shown or encouragement given to him by the staff in the establishment.

Exposure to Fearful Situations

380 Several applicants said that they had been exposed to fearful situations. As noted earlier, some said that the staff would "pitch" the residents against one another and would condone bullying. They referred to the staff actually encouraging the bullying. Another described a regime that included verbal and physical abuse which left him fearful and deeply unhappy. Fear of being abused and unable to tell anyone what was taking place was a common concern.

381 An applicant described his fellow prisoners being taken out of their hut and taken to an 'H' Block. He said he witnessed others being beaten and heard them being brought out of their cells, screaming and pleading with the members of staff to stop. He saw another prisoner being dragged out of a cell by his feet and being beaten on the soles of his feet with a baton. The applicant had initially been placed in a cell with two political prisoners and felt very threatened as they were openly talking about bombings and shootings. He was seventeen years of age and this was his first time in a penal establishment.

382 Death threats were apparently common, according to one applicant. Another described living in abject fear of violence from members of staff, referring to the "emotional terror and living every day in absolute fear". He was told by a member of staff prior to a visit when he had a black eye that, if he mentioned anything about what happened on the wing, he would be denied visits.

Bullying

383 Another applicant highlighted a culture of bullying by other residents and a fear that he would be raped. He said the threat of anal rape was always present. One applicant said that although the establishment "was not a bad place" he was bullied a lot by older residents, both in the pool and in the showers. One response was to run away, which he did frequently, sometimes just across the fields, sometimes to his home and sometimes to the bonfire near his home.

Letters being Censored

384 An applicant spoke of letters being censored "like being in prison" and of being threatened with being sent to other establishments if he did not do as he was told. He also talked of witnessing other boys getting punched "hundreds or thousands of times" but was terrified and too frightened to report any of the abuse.

Removal of Personal Belongings

385 The removal of personal belongings was mentioned by an applicant who stated that his personal belongings, including his much valued stereo (bought as a present for his thirteenth birthday by his mother), were taken by staff.

Other Examples of Emotional Abuse

386 An applicant described being sent to the sick room as he had hurt his back, but as a result had no contact with anyone for long periods of time. He felt that he was in solitary confinement with no contact, no books to read other than a Bible and nothing else to do.

387 Another considered his placement in the establishment as "a wakeup call, a terrible place". He said that he became very depressed and the establishment was run like an army barracks. He apparently became as white as a ghost, with black rings around his eyes and would not talk to others. He concluded by saying that "the screws took out their frustrations on us."

Neglect

388 Eight applicants complained of neglect, focusing mainly on education. They alleged that their education was neglected, their learning potential ignored and their need to develop basic skills unmet.

Education

389 One applicant felt that his education was inadequate and referred to being unable to read and write when he left the establishment. Another applicant pointed out that he was sent to the establishment because of his record of absconding from school but that, ironically, in the establishment he did not attend school. Similarly, one applicant who had been sent to an establishment for truanting pointed out that the establishment did not encourage residents to attend classes.

390 Another applicant felt that there was no proper education, no mental stimulation for the residents in the establishment and that the teachers were uninterested in his educational development. An applicant commented that:

"we received a very, very, very poor education – it was like going back to primary school – I really feel my education suffered by going to (this establishment) where the emphasis was on woodwork, metal work and gardening – not on GCSEs."

391 One applicant said that the teachers didn't want to teach him and that he was allowed to play 'Chucky Egg', a computer game, all day. He said there was no teaching and no learning. He also alleged that older boys gave him 'magic mushrooms' and he would be sitting in class "totally spaced out". No one ever seemed to notice and no one asked him what was wrong with him. He said he had "no art, no metalwork, no history, and no geography."

Inadequate Medical Attention

392 Inadequate medical attention was highlighted by one applicant who had attempted to commit suicide on numerous occasions, including eating parts of a smoke detector and drinking bleach. He said that he did not receive appropriate medical treatment at the time. Another applicant explained that he had hurt his back and the pain was so intense that he was unable to stand with both feet on the ground during parade. He said that he was not given pain relief despite being in a great deal of discomfort.

393 One applicant described an incident when boys playing a ball game in the yard broke a window above where he was standing. The shattered glass fell on top of him and badly cut the back of his head and upper neck. He was taken to hospital where he received stitches for the injuries but still has a large scar as a result. He was told by staff that he could not make a claim because the incident happened in a designated ball-playing area. He believes that responses to accidents and injuries were lax and the attitude of staff was unsympathetic. He said that on one occasion he put his hand through a window and cut himself badly, but believes the incident was not dealt with appropriately.

Lack of Supervision

394 The lack of supervision in some of the establishments was also commented on by applicants. One applicant referred to being bullied and felt there was no appropriate supervision to prevent this happening. Another explained that the country and town boys were separated and he received threats from the Belfast boys that he was going to be beaten up at night. He said that he always felt frightened; staff took no account of this and he felt unable to report the matter as he feared that he would lose his special privileges.

Aftercare

395 One applicant who served thirteen months of a one to three year sentence said he received no preparation for life and work in the community and was simply told one day that he "was going."

Females: Juvenile Justice Provision

396 Thirteen female applicants who had been in three different juvenile justice establishments made fourteen reports of alleged abuse. There were eleven complaints of physical abuse, nine complaints of emotional abuse, seven complaints of sexual abuse and six complaints of neglect.

397 The combinations of types of abuse they alleged are set out in the following table.

Abuse types	Females	Establishments
Physical, sexual, emotional and neglect	2	2
Physical, emotional and neglect	3	3
Physical, emotional and sexual	2	1
Physical, sexual and neglect	-	-
Physical and neglect	-	-
Physical and emotional	1	1
Physical and sexual	2	1
Emotional and sexual	-	-
Emotional, neglect and sexual	-	-
Emotional and neglect	-	-
Emotional	1	1
Sexual	1	1
Physical	1	1
Neglect	1	1
Total	**14 reports**	**3 different establishments**

Note: One establishment was the focus of eight complaints. Two other establishments were the focus of three complaints each.

Physical Abuse

398 Physical assaults involved punching, hitting, kicking, having hair pulled, being spat on and assaulted with objects such as a bunch of keys. Some applicants said they were physically restrained in ways they considered abusive.

399 An applicant described a physical assault that she endured after running away from her establishment and being found glue sniffing. She said that when she was brought back to the establishment and taken to the office with two other female residents, a male member of staff grabbed her as she tried to escape through the window and pinned her against the wall, knocking her unconscious, and she came round with blood coming from her head. She was taken to hospital for treatment. The senior member of staff present was described as being furious because she had tried to escape yet again.

400 Another applicant said she saw the priest who was conducting Mass one day slap one of the girls across the face because she came up to the altar wearing lipstick. Another applicant explained that a member of staff would put on white gloves and inspect their rooms for dust. If there was any dust on the white glove, she would thump and beat the girls and wreck the room.

401 One applicant told the Forum about a member of staff in her establishment. She was a big woman who was verbally and physically abusive, pushing, slapping, dragging, flinging people about and beating them. She said that she still has nightmares about this woman.

402 Being placed in some form of solitary confinement was mentioned by a number of applicants. One of these was being sent to the Day Room which was a room with "nothing in it other than a potty" – there were no other sanitary provisions. She felt that this was a punishment that was used regardless of what she had actually done and commented that "I must have spent one and a half years in that Day Room."

403 One applicant talked of being restrained, as were other residents, by members of staff who held them face down on the floor and also held them by their arms and legs when they were moving them from one room to another. She said "they had no consideration for the residents' modesty"; she explained that often she wore jogging bottoms which would come down when she was being restrained. Sometimes she would be placed in a particular room for periods of up to 72 hours on her own. In

addition, she also mentioned being kicked and spat upon by members of staff. Other applicants said that they were regularly placed in the "lock-up unit" for between 24 and 48 hours, often for running away.

404 One applicant stated that she was regularly bullied by other residents and that staff laughed at her if she reported it. Another explained how other girls would sit on her bed and urinate on it in order to get her into trouble. In the bathroom they would squeeze toothpaste on her head. Staff responded to this by telling her she had to learn to stand up for herself.

Sexual abuse

405 The incidence of sexual abuse disclosed by the female applicants within the juvenile justice category was similar to that of their male counterparts. Seven applicants recalled sexual abuse.

Grooming

406 One applicant explained that soon after her admission to the establishment she was "set aside" by a male member of staff: "He paid me more attention." She trusted him and told him about the abuse she had experienced at home, including sexual abuse. He hugged her when she cried and always came to her aid when she asked for him. As he was a senior member of staff she said that he had a great deal of power. This grooming behaviour escalated, progressing from kissing her to full sexual intercourse on a regular basis, from the age of sixteen through to eighteen and beyond, including after she had left the establishment.

407 Other applicants spoke of grooming behaviour leading to indecent assaults. For example, one male member of staff apparently used every opportunity to grope the residents, including putting his hands under their tops and down their tracksuit bottoms. He would send them birthday cards and give them little treats even though the applicant stated he must have been aware that they did not like being touched.

Indecent Assaults including Inappropriate Fondling

408 An applicant said that staff would wait outside the bathroom but look in through the glass panel above the door. She said one member of staff would pretend to tickle her but would be groping her and fondling her breasts. She said "it was horrible – there was no one to protect you."

409 One applicant, after being locked in her dormitory at night, would be allowed out by a male member of staff so that she could smoke a cigarette. She

said that "he was always trying to touch me up." When she complained to him he said:

> "a silly wee girl like you and a trouble maker, who is going to believe you?"

Other Inappropriate Sexual Behaviour

410 Another form of inappropriate sexual behaviour was alleged by an applicant who described circumstances in which she was examined by the woman in charge of the establishment and was required to take her pants down; a man, whose role to her was unknown, was present throughout. She also spoke about a situation in which she needed sanitary pads and the woman in charge checked her pants, again in the presence of the man whose role was unknown to her.

Emotional Abuse

411 The emotional abuse disclosed by nine female applicants in the juvenile justice category focused on the related areas of public humiliation, personal denigration, family denigration and the discouragement of sibling and family links. Being shown no affection and an inappropriate exposure to fearful situations were also commented on by some applicants.

Personal Emotional Abuse

412 An applicant described a points reward system in her establishment. Each week in front of everyone else, each girl's reasons for having points deducted was explained in detail; she said they found this humiliating. She also mentioned a "loud" female member of staff, whom she described as a bully, who was responsible for verbal and physical abuse and of whom everyone was terrified. The member of staff frequently made derogatory remarks to the girls; for example, she would refer to the applicant and three other girls from Derry/Londonderry as the "Derry Hogs".

413 Another applicant was made to strip naked and stand in line with the other girls to shower. She felt humiliated and despite asking staff if she could get in the shower in underwear or be the last in, she was sneered at and told to strip.

414 An applicant mentioned that when restrained or being physically moved by staff, there was no regard for the modesty of the resident if the displacement of clothing revealed personal areas.

Personal Denigration

415 Personal denigration was reported by a number of applicants. One asked for a bra like the other girls but the member of staff she had asked commented "you need a chest before you get a bra." Another applicant was made to feel inferior by the constant taunting by older girls and staff as she was very small and because they referred to her as not having breasts. She said that this behaviour was never challenged by any member of staff. Another applicant was constantly told "you're dirty, no one wants you, you're bad," and another was mocked for her slight build. One applicant was told her family didn't want her.

416 An applicant stated that she was repeatedly placed in solitary confinement, where she was frightened, hungry and lonely. She was subjected to name-calling, family denigration, disbelief, and threatening behaviour from staff. She was bullied by other residents. She was blamed for others' misbehaviour. As she saw it, she was made a scapegoat in the establishment, just as she had been at home and in school.

417 Another applicant explained how they were given an allocation of five cigarettes a day, but that staff used to "wind them up" until someone swore and the staff would then cut up their allocated cigarettes in front of them.

Sibling and Family Links Discouraged

418 Applicants described how sibling and family links were discouraged or forbidden and, in one case, how even personal friendships within the establishment were discouraged.

419 An applicant and her identical twin sister who were in the same establishment were not allowed to visit each other and only saw each other at school, where they were in different groups. When her sister became ill from a self-harming incident and was in hospital in intensive care, the applicant was not informed, and was not allowed to visit her in hospital or see her on her return. The applicant considered that this was a most destructive act for her to contend with as they were so close. This situation was aggravated by the fact that she was not permitted to have appropriate contact with her parents when they visited, although her twin sister was allowed to meet them.

420 An applicant told the Forum that she and another girl in the same establishment, who had developed a close friendship, were forbidden by staff from seeing each other and her friend self-harmed by slashing her wrists with a razor blade in response to this ban.

Deprivation of Affection

421 Being shown no affection was commented on by some applicants. They explained:

> "There was no affection or emotional support; it was a very harsh regime, the staff had no time for you. If you got upset there was no one to speak to. They treated us like dogs; it was like being in prison – we were in care, not young offenders. Other kids bullied you, staff would ignore it and just laugh at you if you reported it; it was a horrible place with horrible people."
>
> "I was constantly being told that no one wanted me and that I was a bad girl – bad not mad."

Exposure to fearful situations was also mentioned by applicants who said that the totality of the abuse culminated in a fearful environment.

Neglect

422 Six of the female applicants who had been placed in juvenile justice establishments alleged neglect.

Education

423 One applicant said that no education was offered to her and she had concluded that it was not even considered as an option for her to attend school. This applicant felt let down and blamed staff in the establishment and the social workers allocated to oversee her care. Education, as she experienced it, consisted of making baskets and she alleged that no formal arrangements for general education were made for the residents. One applicant when aged eleven was placed in a classroom with sixteen and seventeen-year-old girls, and felt terrified and unable to complete the school work. She felt unable to ask for help from the teachers even though most of the other residents were much more advanced in their work.

424 Another applicant commented that her education in the establishment was deficient despite the fact that she had been placed there for missing school. She said that "often we were just given a PlayStation." One applicant complained about her schooling in an establishment saying:

> "School? They didn't educate you. I was taken from a grammar school to this. They did not teach you anything – no education; no exams."

Bedding

425 An applicant spoke of the sleeping arrangements in the establishment and the lack of adequate bedding. She said that she was in the reception unit for six months. She talked of being:

> "locked in, having no space, there were lots of kids in a small room. Staff and other kids would bully you; if one of us messed about, all were punished. The staff were very harsh – they had no time for you – they would just push you away. I felt like a prisoner; there was little fresh air, I slept in a dormitory on an old blue gym mattress with a sheet on the floor."

Inadequate or Inappropriate Diet

426 Some applicants spoke of having an inadequate or inappropriate diet, sometimes with no food at all. One said that the food was terrible and undercooked; for example chicken with blood still in it, but that they were still forced to eat it. One applicant described being deeply upset by the harsh, inflexible regime and the lack of provision for her basic needs. She was vegetarian and yet in the establishment she was served meat and told there were no alternatives.

427 One applicant said that when she was in solitary confinement she was often overlooked at lunch time. She said that as she didn't like some of the regular food she was often hungry and that no-one monitored her weight, even though she was very lightly built. Another applicant, when thirteen-years-old, took an overdose of medication that resulted in her being hospitalised for a week. When she returned to the establishment she was immediately sent to a room and not given any food. She said that she was "not given one piece of bread in three days".

Inadequate Medical Attention

428 Inadequate medical care was commented on by an applicant who often self harmed by cutting herself, but when she did she was not taken to hospital but was just bandaged up. Poor hygiene was mentioned by one applicant who complained that she was not given sanitary pads when she needed them.

Inadequate Aftercare

429 One applicant told the Forum that when she left the establishment she was transferred to a hostel, but found it a terrifying place with adults who were drug abusers and were involved in other anti-social behaviour. She

was so scared that she would stay in her room. She told the Forum that:

> "there was no after care. I was given a cheap box of food and sent on my way. I didn't know how to boil an egg; no one took an interest in your needs."

Reporting of Abuse: All Establishments

430 Of the 103 applicants within Period 3, 34 reported their abuse to someone on at least one occasion. Some had reported abuse on more than one occasion, to more than one person or whilst in more than one establishment. The following table shows the number of applicants who reported abuse, to whom they reported the abuse and if they were believed about the abuse.

Reporting of Abuse at the time and to whom							
Reported To	Total	Voluntary		State		Juvenile Justice	
		Believed		Believed		Believed	
		Yes	No	Yes	No	Yes	No
Parent	7	2	1	2	1	1	-
Sibling	2	2	-	-	-	-	-
Social Worker	11	3	3	1	3	1	-
Officer in Charge	3	1	-	-	-	2	-
Care Staff	9	2	1	-	3	2	1
Ancillary Staff	1	1	-	-	-	-	-
Authority Figure	5	1	1	-	1	-	2
Other Adult	1	-	1	-	-	-	-
Other Resident	3	1	-	-	-	2	-
Other Child	1	-	-	1	-	-	-
Police	3	-	1	-	-	2	-
Total	**46**	**13**	**8**	**4**	**8**	**10**	**3**

In summary, in relation to the 46 occasions when they had reported abuse, applicants felt that they had been believed on 27 of those occasions and not believed on nineteen. Some comments from those applicants who considered that they had not been believed are set out by establishment type below.

Males and Females: Voluntary Establishments

431 One applicant said:

> "Despite having told my parents and the fact it was clear that I was distressed and didn't want to return to (the establishment), having been home for the weekend, my parents apparently did not believe me."

Another applicant explained that when she complained to the staff about her abuse, no action was taken and she was told "not to tell jokes". An applicant, who told his probation officer that he and his brother were being abused, was told they "were both disgusting – how can you say that?" A female applicant said that no one ever believed anything she reported and as a result she trusts no one to this day. Another applicant disclosed the abuse to her mother but she did not want to know and could not accept that such a thing would happen in a church-run establishment. An older member of staff said to an applicant who had told her about his abuse: "We'll get these beasts. God is powerful," but she took no action. He believes she did not report the abuse because she was frightened she would lose her job.

State Establishments

432 An applicant said that he had told both his key worker and social worker but neither of them believed him.

Juvenile Justice Establishments

433 A male applicant reported the abuse to a senior member of staff and was told that it did not happen and that he had nightmares. However, when he insisted that it had, he was told:

> "Don't be awkward – if you make false allegations then things will get bad for you!"

434 Another applicant said his mother told him to "shut your mouth – you'll get us into trouble." Other applicants felt that they had been believed but that little action if any was taken by the people to whom they reported the abuse. One applicant who spoke to a member of staff felt that he had been believed but the response was "Sorry, I can't help you." An applicant who disclosed his abuse to his parents was told by them that if he went to the police he would be a "tout" (informer).

435 Some applicants said that it was not that their complaints were disbelieved but that the people they complained to did not want to know. A male applicant who had reported his abuse to staff said their response was just to laugh at him and not do anything about it. Another applicant who reported the abuse she had experienced was told she had to learn to stand up for herself.

Chapter 6:

Chapter 6: Life After Care

Applicants' Current Circumstances

1 During their meetings with the Forum, many applicants talked about their current circumstances including relationships, children, employment and health. Over half of the applicants had at one stage been married, although at the time they met the Forum some were widowed, divorced, separated and re-married. The applicants' experiences of marriage were mixed, with some marriages ending in a short time but with others enduring for many years. For example, one applicant had been married for 48 years and another for 58 years. One-hundred-and-sixty-nine of the 262 male applicants told the Forum they were or had been married and of that number 76 had been married for ten or more years. One-hundred-and-two of the 167 female applicants told the Forum that they were or had been married, and of that number 47 had been married for ten or more years.

2 Applicants who were still in long-term relationships, including marriage, often described their relationship as being strong, caring, stable or very supportive. For many of the applicants whose partners accompanied them to the meeting with the Forum, the support they spoke of was evident. A male applicant said that his wife had saved him and that he would have been dead if it had not been for her support. Likewise, a female applicant explained that she and her husband were about to celebrate their fiftieth anniversary. In the past she had "put him through hell but he is the reason I am still here". Some applicants described their partners during the meeting with the Forum using phrases such as "an amazing woman", "a fantastic person." Others said "my wife has been my strength," and "I married a good man."

3 Applicants with long marriages explained that it had not always been easy but that their strong relationships had helped them deal with the problems and, for some, having a family had a strong, positive effect in their lives. One applicant said that whilst his wife and he had a good marriage now, he had been violent in the past but they had worked through their difficulties.

4 Another applicant said that his marriage had survived a difficult initial period that resulted from the absence of loving, caring relationships when he was a child in care. He said that this, coupled with his deep-seated anger at his treatment as a child, made him severe in his attitude and behaviour

towards his own children. Some applicants who spoke of having a strong relationship now said they had experienced problems in the early years of their relationships. They referred to difficulties that included problems in expressing their feelings or relating to their partners, finding it hard to trust them, being over protective of their children and abusing alcohol.

5 It was noted that some applicants had only recently disclosed their childhood abuse to their partners and others still did not feel able to tell them. One applicant said that he was very happily married but that his wife did not know about the abuse he had experienced, commenting "How would telling her help?" Those who were widowed echoed many of the previous observations made by married applicants, for example, "The only thing that has been good in my life was getting married." Applicants who had sustained long-term co-habiting relationships spoke in a similar way regarding supportive partners who provided stability in their lives.

6 Applicants in other forms of relationship appeared to have encountered similar problems, which they believed had contributed to their current relationship status.

These included:

- an inability to trust partners, feeling unable to trust anybody, difficulty in being close to people, and problems with intimacy: "personally I found it difficult to express my affection to others; I was unable to embrace my partner or tell her that I loved her."
- a lack of confidence
- flashbacks to sexual abuse
- concern that he or she would not be able to love anyone because of abusive experiences as a child
- deciding not to have children because of the worry that they might also end up in care

7 Applicants also spoke of relationships affected by

- verbal abuse
- sexual abuse
- physical abuse/anger management problems
- controlling behaviours
- alcohol related problems

One applicant expressed his thoughts as to why his relationships had not worked out saying he felt that he and his siblings who had been in care had been institutionalised and, from his perspective, he saw "everyone else as an alien", and felt so different from others.

8 Over 75 per cent of the applicants who provided information about their current circumstances told the Forum that they had children. For them, having children was a very positive part of their lives. Applicants spoke with evident pride regarding their children's achievements in education, employment and family life. A number of applicants felt their childhood experiences resulted in them being over-protective of their children; others found it hard to show affection towards their children and had encountered problems in establishing stable relationships with them.

9 One applicant expressed regret that she had felt unable to love her son as much as she feels she should have. Another said that she wanted to be the best mother she could be and had tried too hard at times. A male applicant said that he had no yardstick as to what a father should do but had learned by observing his father-in-law; he added that his children and wife all tell him they think he is a good dad. An applicant who spoke of being over protective of his children said:

> "I created a bubble for them. I wanted to do everything I could to shield them from possible harm. I realise that I went too far."

Some applicants had chosen not to disclose information regarding their abuse in institutions to their children. Comments included:

> "I have not really talked to them about abuse as I don't want to burden them with it. I have told them I will sit down with them one day to tell them about it."

> "My children do not know about my abuse as I am frightened of hurting them."

Employment

10 Information about their current employment was provided by some applicants and is summarised in the table below.

Employment	Total	Male	Female
Employed	75	48	27
Self employed	25	21	4
Retired	98	59	39
Volunteer	9	2	7
Working at home	10	3	7
Unemployed	93	67	26
Disability – unable to work	49	29	20
Unknown	63	29	34

11 The many applicants who were employed (whether currently or previously) worked in a wide range of occupations including the following:

- Trades – building, construction, retail
- Emergency services – police, ambulance, fire brigade
- Security
- Armed services
- Managerial, civil service, secretarial
- Catering, including hotel trade
- Nursing, medical profession, hospital and care facilities staff
- Social work, probation, counselling

A large number of applicants had worked in the home rearing their children and some looked after their grandchildren. Some applicants said they had been unable to work because of a disability, either physical or psychological or both.

12 Many of those applicants who were currently unemployed had been employed at some stage but had been unable subsequently to obtain employment. Many of them had been in short-term employment but explained that they felt hampered by their lack of qualifications and by being 'unskilled'. An applicant said "I have been unemployed for many years but I would love to get a job." One applicant attributed his inability to hold down a job to his intolerance of anyone in authority telling him what to do. He attributed this problem to his abuse in an establishment.

13 Some applicants worked in voluntary positions, notably helping vulnerable people, for example in a food bank, drop-in centre, shelter and as foster-carers. Others worked at home caring for relatives with health problems or special needs and some looked after grandchildren. Caring for and helping others was significant in many applicants' priorities.

Health

14 Many applicants mentioned matters relating to their mental health including psychiatric admissions, suicidal ideation, suicide attempts, self-harm, and dependence on prescribed medication. Many of the applicants considered these to be outcomes linked to the abuse they had experienced as children in residential establishments. They said that their childhood experiences continued to have a negative impact on their adult lives.

15 Some applicants did not disclose any information relating to their health but those who did spoke of experiencing depression and other mental health difficulties that sometimes required admission to a psychiatric hospital unit or supported and supervised care in the community. Some applicants related their feelings of suicidal ideation and attempts at suicide or self-harming to their childhood trauma.

16 In relation to contemplating suicide one applicant said:

> "I think about it – the place never goes away – it is my children who keep me here."

Another said "I didn't want to die, but I didn't know how to live". Several applicants spoke of the pain they felt about friends who had been in institutions with them and who had committed suicide.

17 Many applicants also highlighted the incidence of substance abuse in their lives, including alcohol, drug and solvent abuse, both within their personal experience and also in the lives of others they knew as survivors of childhood abuse. Many spoke of the successful battles they had fought to overcome their reliance on alcohol and explained that they were now 'dry' with the help of organisations such as 'Alcoholics Anonymous' but also with the additional support of their partners and families.

18 Some applicants explained that they had benefitted from counselling, some for several years, whilst others said that they were not interested in counselling. Others found it of limited use to them personally and two applicants made the following comments:

"I didn't really get anything from it – it doesn't take it away but I have learnt to live with it."

"I did not get anything out of it. How can you understand from the outside looking in?"

Many applicants said they were taking prescribed medication for depression or anxiety.

19 Some applicants, in the course of their meetings with the Forum, went into great detail regarding their health and brought with them medical reports to support their accounts of the effects of the abuse experienced in residential childcare establishments.

Effects of Experiences in Care in Later Life

20 Applicants were asked to comment on what effect, if any, their experiences in care had had in later life. A number of them re-iterated the matters they had spoken of when talking about their health in adult life and many mentioned other negative outcomes. An analysis of what they told the Forum indicates that more than 40 different effects were mentioned in some way by at least one applicant.

21 Fifteen negative effects were reported by larger numbers of applicants than others and these are set out in the following table.

Stated effects of experiences in care	Total	Male	Female
Counselling needed	186	115	71
Dependence on medication	153	92	61
Inability to trust others	151	94	57
Suicidal ideation	138	89	49
Experiences in care not easily forgotten	135	91	44
Substance abuse	128	95	33
Feeling anxious or fearful	115	67	48
Lacking self-worth	114	60	54
Suicide attempted/self-harming	114	72	42
Having feelings related to being a victim	103	58	45
Experiencing flashbacks	98`	70	28

Stated effects of experiences in care	Total	Male	Female
Feeling angry	97	68	29
Feeling different from peers	81	45	36
Feeling isolated	78	53	25
Becoming a loner	75	49	26

22 Commonly applicants mentioned more than one negative effect as is indicated in the following table.

Number of negative effects reported per person						
	1	2	3	4	5	6+
Male	40	37	19	28	27	106
Female	15	29	24	22	11	52
Total	**55**	**66**	**43**	**50**	**38**	**158**

Chapter 7:

Chapter 7: Applicants' Responses to the Acknowledgement Forum

Participation in the Forum

1 Applicants were asked after their meetings with the Forum if they would accept a call from their WSOs about a week later. The purpose of the contacts was to ask how the applicants were feeling following their meetings and, where necessary, to encourage them again to get in touch with the dedicated support service or their own doctors, counsellors or other health personnel. Almost everyone agreed to this arrangement and WSOs succeeded in contacting the majority of applicants by phone. Where that was not possible they wrote to them.

2 Thirty-eight per cent of male applicants and 30 per cent of female applicants told the WSOs that they felt good or better than previously as a result of having met the Forum. They were comfortable with the process and the arrangements and were very appreciative of having had the opportunity to take part.

3 Twenty-three per cent of male applicants, and 37 per cent of female applicants, said that they found the experience of recounting their abuse to be difficult and painful, but they had no regrets about taking part in the Forum. "It had lifted a burden" was how one male applicant described the process, a sentiment repeated by many others. The applicants in this group expressed their appreciation for having had the opportunity to speak to a listening audience and for giving their voices an opportunity to be heard.

4 A small number of applicants, nine men (three per cent) and six women (four per cent), told their WSOs that participation in the Forum process had proved extremely difficult and had left them drained and feeling 'down'. Most of these applicants, by their own description, were people who felt insecure much of the time and led lonely or even solitary lives; a number of them had mental health needs. Even in the context of these outcomes, they said they had needed to take part in the Forum process.

5 Thirty-four per cent of male applicants and 30 cent of female applicants made no direct comment on their experience of the Forum, but generally they reflected satisfaction with the process.

6 A small number of applicants, seventeen (seven per cent) of the males and eleven (seven per cent) of the females, did not respond to the WSOs' attempts to contact them by phone or letter and so no information is available about their responses to the Forum process.

7 The following comments, noted by the WSOs, are a representative sample of what applicants said about participating in the Forum:

"She was glad she had taken part as it didn't take as much out of her as she thought."

"He felt all went well, like a weight had been lifted off his shoulders."

"She had mixed feelings after meeting the Forum - it brought back lots more memories."

"He was very glad that he had spoken to the Forum and felt they were very nice and understood him well."

"He found the whole process worthwhile and was very grateful to the inquiry for coming over to Australia."

"It was good to have spoken to the Forum and to have them listen to him. He said it was a little bit of closure for him."

"She is feeling a great sense of relief and that it all went a lot better than she had expected."

"He wanted to say that he had felt very much at ease from the moment he arrived in Belfast and he had been treated really well before, during and after his meeting. He wanted to thank the Forum for that."

"She had gone to pieces after she had left the meeting with the Forum but had found the experience less stressful than she had anticipated. She felt no pressure and was able to talk at her own pace."

"Meeting with the Forum was the best thing she has ever done – she said she has now left all her baggage with the Forum members - who she described as very warm and very professional people. At no time did she feel people were just doing their job, she felt everyone really cared."

"The Acknowledgement Forum paved the way forward for survivors to tell their stories; this was a vital and necessary component."

8 Other feedback reported by the WSOs included the examples below.

- An applicant asked the WSO to pass on his heartfelt thanks to the Forum members for their sensitivity and for really listening to him. He said this would go a long way towards his healing.
- An applicant told the WSO that on the bus after meeting the Forum he was really happy. Since then he has just been on his own and the past couple of days he can't stop thinking about it. He said it takes over and he just sits and thinks about it for hours at a time. Even so, he is really happy he met with the Forum.
- An applicant said that she was doing well, and speaking to the Forum members was a massive relief and release. She has been a little upset and had some sleepless nights since, but she was coping well as it was her first time telling anyone. She felt that while she was a victim, she was more a survivor.
- Another applicant told the WSO that it was such a relief to have spoken to the Forum and she felt that a huge weight has now been lifted. She thanked everyone very much for making it so easy.

Conclusion

9 Many applicants, at the end of their meetings with the Forum, expressed satisfaction with the process and procedures of the Forum. Some of their recorded comments were as follows:

"This is the first time I've spoken about this to anyone."

"You are the first people who have ever heard my whole story."

"This is the first time I've actually been listened to."

"I never thought I would be able to go through with this."

"I have more I need to say, but not yet."

"I'm glad I came."

"Thank you for letting me come. How did I do?"