

Chapter 15:

Module 7 – Lisnevin

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Introduction

- 1 We considered evidence about Lisnevin Training School (Lisnevin) during Module 7, which dealt with juvenile justice institutions. Module 7 commenced on 01 September 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 Lisnevin¹ and gave evidence in person. We also received a statement ²and 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 1995⁷ 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 1988²⁹ 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 1993⁵³ and 1994⁵⁴ and two unannounced inspections in 1993⁵⁵ 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 supplementary 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 residents⁸⁷ 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 statement¹⁰⁸ 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 injuries¹²⁸ 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 resident¹⁵⁰ 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 bedroom¹⁵⁴ 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 as 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.**