

Chapter 24:

Module 13 – Lissue Hospital, Lisburn

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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 party⁶ 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 recognition⁶⁶ 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 Lissie 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 Lissie 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 Lissie, or that he abused any child at Lissie, 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 Lissie’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 Lissie. 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 Lissie Hospital were referred through the Royal Belfast Hospital for Sick Children, though general practitioners at times referred children directly to Lissie. 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 Lissie.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 Lissie 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 Lissie 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

Lissie 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 Lissie 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 Lissie 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 Lissie 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 Lissie, 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 Lissie 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 Lissie 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 or³²³ 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 Lissie 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 staff³⁷⁵ 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 Claims³⁸⁴

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 Report³⁹⁴

- 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 Report³⁹⁷

- 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 Report⁴⁰⁶

- 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 Report⁴¹⁰

- 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 Response⁴¹⁴

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 Summary⁴¹⁵

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 Report⁴¹⁷

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 Report⁴¹⁹

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 Report⁴²⁷

- 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 closed⁴³¹ and the establishment of the Historical Institutional Abuse Inquiry had been announced.⁴³²

The McAndrew Overview⁴³³

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.**