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HISTORICAL INSTITUTIONAL ABUSE INQUIRY

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being heard before:

SIR ANTHONY HART (Chairman)

MR DAVID LANE

MS GERALDINE DOHERTY

held at

Banbridge Court House

Banbridge

on Monday, 4th April 2016

commencing at 10.00 am

(Day 195)

MS CHRISTINE SMITH, QC and MR JOSEPH AIKEN appeared as Counsel to the Inquiry.

Monday, 4th April 2016

(10.00 am)

Opening statement in Module 13 by CHAIRMAN TO THE INQUIRY

CHAIRMAN: Good morning, ladies and gentlemen. Can I welcome you all to this, the 195th day of our public hearings, and today, as Ms Smith QC in a few moments will explain, we start our public hearings into what we term Module 13, during which we will be investigating a number of matters concerned with the Lissue Hospital Unit.

I want to take this opportunity to state yet again what I made clear in my remarks on 4th November last year. In this module the Inquiry is not concerned with an examination of the propriety of particular forms of psychiatric treatment of children at Lissue. This Inquiry does not have the medical expertise to carry out such an investigation, and if a view is taken that such an examination is required, then a different form of Inquiry with the necessary expertise and psychiatric paediatric medicine will be required to do that.

One further matter I should perhaps mention for the benefit of anyone who has not been at our proceedings before is that from time to time there may be mention of a name or names of individuals to whom we have given designations in order to preserve their anonymity.

Sometimes it is necessary to mention their names here in the chamber, because otherwise it is simply too difficult for everyone to follow what is going on, but those names, if they are given, must not be used outside the chamber under any circumstances.

Now Ms Smith.

Opening statement in Module 13 by COUNSEL TO THE INQUIRY

MS SMITH: Good morning, Chairman, Panel Members, ladies and gentlemen. I should say, Chairman, today we start our public hearings into Lissue Hospital Unit and, as you have also emphasised, this Inquiry is not concerned with an examination of the propriety of particular forms of psychiatric treatment of children, as we do not have the medical expertise to do that. Rather the Inquiry is concerned in this module, as in every other, to look at the nature and extent of any abuse that occurred and determine whether such abuse was caused or facilitated by systemic failings.

As with the institutions we have looked at previously, the alleged abuse that you hear about from those who will give evidence in this module covers physical, sexual and emotional abuse by staff members. From other material you will hear that peer sexual abuse of children was also a feature of Lissue.

All but two of those who have come forward to speak

about Lissue were resident in the Psychiatric Unit.

One person speaks about a time when he was extremely young and the Inquiry has been told that, although no records of him being in Lissue exist, it is thought that he is likely to have spent time in the unit as a convalescent.

Another person was admitted to the Paediatric Unit, where he alleges a male nurse sexually abused him.

One person is now deceased. The Inquiry has learnt from the Health & Social Care Board that he was one of the earliest admissions to the Psychiatric Unit.

Lissue House is in a wholly different category to the other institutions that the Inquiry has looked at in that it was a hospital unit as opposed to a children's home or training school.

I am now going to outline a little about the history and background to this institution, and I am grateful to the joint statement from Fionnuala McAndrew, Mary Hynes and Dr Carolyn Harper from the Health & Social Care Board and Public Health Authority responding to the Inquiry's request for information dated 29th February 2016 and to the statement of Dr Hilary Harrison of the Department of Health, Social Services & Public Safety dated 25th March 2016, and to the statement of Aiden Murray from The Health & Social Care Board dated

31st March 2016 for much of the following.

The Inquiry has also received statements from some of the staff that worked in Lissue and will hear oral evidence from witnesses next week.

Lissue House, situated in Ballinderry, just outside Lisburn, was first used during The Second World War, when children from The Royal Belfast Hospital for Sick Children were evacuated to the house, which was offered for that purpose by the Lindsay family, whose home it was.

We can see the layout of the hospital from the Land Registry documents, which are at LIS12699, and there are photos of the house in a chapter of "The Royal Belfast Hospital for Sick Children - a History 1948-1998" by Harold Love that is annexed to the statement of Dr Hilary Harrison at LIS089.

If we could look at 089, please, you can see here the front of Lissue House building. If we can scroll down to the next page, we can see an interior shot showing a staircase, which one of our applicants to the Inquiry has described in his statement. There is also a further photograph at 12792, again showing the exterior of the building.

After the war the Northern Ireland Government refused to pay for the continued use of Lissue and it

was vacated by the hospital. There are papers at LIS12811 through to 12834 dealing with compensation for the reinstatement of Lissue House following its wartime use.

The need for a convalescent home for children remained an issue, however, and in 1948 the Lindsay family donated the house to The Royal for use as a branch of The Children's Hospital. Lissue House opened in 1948 as a Paediatric Convalescent Unit for The Royal Belfast Hospital for Sick Children. By 1959 Lissue had become a busy branch hospital of The Children's. It had seventy beds for both surgical and medical treatment.

Due to the increasing need for an In-Patient Child Psychiatric Unit plans were developed in the late 1960s to convert part of Lissue for this purpose. Plans can be found at LIS12837 to 12840. Paediatric beds at Lissue were unavailable for a period of one to two years while renovations to convert the first floor were carried out.

Then in 1971 a Psychiatric In-Patient Unit for children opened on the first floor of Lissue House. This was the first such facility for children in Northern Ireland. It provided twenty in-patient beds and catered for five day patients. A multi-disciplinary

team of doctors, social workers, psychologists and nurses provided by The Royal staffed the unit. The team was led by Dr William Nelson, from whom the Inquiry will hear evidence next week.

Children were generally admitted to the unit for short-term treatment, and figures for the years 1974 to 1983 can be seen at LIS1279. If we could look at that page, please, 12793. We can see here that there are two tables covering each of the two units in Lissue, The Paediatric Unit at the top of this page, which shows that there were thirty-eight available beds in 1974 and in 1983 there were only twenty beds. It shows the admissions during that period, the throughput, the average length of stay and the occupancy and whether or not there was a waiting list.

If we scroll down, please, we see the trends in child psychiatry between those years. We will see there were twenty beds available, although in 1982 twenty-one beds were made available. The occupancy of the In-Patient Psychiatric Unit was certainly above 80% in all of those years, whereas if we look back, you can see that there is an occupancy level in The Paediatric Unit of a maximum of 72.6%, but generally in or around 40 to 50%.

There is the -- if we look at the next page, please,

this gives an idea of the staff levels as they were at the end of 1983. You will see that of the thirty-nine nursing staff in post on 31st December 1983 twenty-four were trained nurses; there were thirty ancillary staff and general staff; two professional and technical staff; and two clerical staff, making a staff complement for the hospital of seventy-three persons.

There is an analysis of costs given, which showed that the cost per in-patient per week for '83/'84 was £449.87.

In addition to the two units there was a school on site at Lissue. Initially children were taught at the bedside and then in 1956 new classroom accommodation was made available for those patients who were able to leave their beds.

Outdoor activity was seen as an important feature of treatment by medical staff and there was a large play area, a photograph of which can be seen at LIS817.

Dr Roger McAuley was appointed in 1975 and he introduced behaviour modification programmes from 1976. In 1977 parental accommodation on site was provided to allow for family admissions. In 1980 treatments extended to include family therapy.

A history of Lissue written in 1981 and found at LIS12781 through to 12789 states that due to changes in

how children were cared for, Lissue's Paediatric Unit eventually cared for those children who were, according to the history, chronically disabled. From 1977 respite care was also offered to the families of those who were mentally or physically handicapped.

The building was not ideally suited for the purposes of a hospital unit, which dealt with a wide range of patients and. according to the book to which I have previously referred on The Royal, staff referred to it as "Legoland" and it would appear some children called it "The Zoo", obviously mishearing the word "Lissue".

While it is not for the Inquiry to look at the treatment of those resident in Lissue generally, the Inquiry may feel that the provision of facilities on site for parents and the fact that, as will be seen, children returned to stay at home frequently places those who have spoken to the Inquiry about their time in Lissue in a wholly different category from many of those the Inquiry has heard from to date, those who were either orphaned or had no opportunity to leave the institution in which they were resident.

Lissue closed in 1989, when all psychiatric services were transferred to what was formerly The Nurses' Home at Forster Green Hospital on the Saintfield Road in Belfast. The Paediatric Unit moved to accommodation at

Belvoir Park. Lissue itself, despite having an offer for the purchase of the property accepted in 1994, according to the book that I referred to earlier, had been empty and run down before being ultimately destroyed by fire in 1996.

Unlike all of the other institutions that the Inquiry has been looking at, Lissue was a hospital and was governed by entirely different legislation. Three key pieces of legislation covered how Lissue and other hospitals operated. Initially the Health Services Act (Northern Ireland) 1948 and then the Health Services Act (Northern Ireland) 1971 covered the time before Direct Rule. Thereafter the Health and Personal Social Services (Northern Ireland) Order 1972 was the relevant piece of legislation. The Health & Social Care Board, Public Health Authority and the Department of Health, Social Services & Public Safety have been unable to identify any subordinate legislation governing the management and operational issues with which the Inquiry is concerned.

In the joint statement of 29th February 2016 the co-signatories of the Health & Social Care Board and Public Health Authority state that prior to 1973 Lissue operated under the authority of the Northern Ireland Hospitals Authority, which reported to the Ministry of

Health and Local Government.

As Dr Harrison states at paragraph 6.1 of her statement:

"Under the 1948 Act the Northern Ireland Hospital Authority, which was a body of volunteers headed by a significant public figure, was responsible for the development, coordination and overall control of hospital and special services, but the duty of administering those services was entrusted to hospitals' management committees. The committees were responsible for day-to-day running of hospitals, acting as the agents of the Hospital Authority."

From October 1973 Lissue became the responsibility of the newly formed Eastern Health & Social Services Board, and administrative control moved from North & West Belfast District, which covered The Royal Belfast Hospital for Sick Children on the Falls Road, to the Lisburn District. According to the account in Mr Love's history, this was despite the view of the Ministry of Health, that felt Lissue should be an exception to the general principle that area boards be administratively responsible for all facilities in their area. We can see that on the preceding page on the screen at 816.

There was, however, power under the 1948, 1971 and 1972 pieces of legislation to inspect hospitals.

Neither the Health & Social Care Board nor the Department have evidence of the exercise of this power in relation to Lissue. It is believed likely that members of the Belfast Hospital Management Committee would have visited Lissue until 1972, when civil unrest in Northern Ireland brought about the deferral of such visits. It is also believed that the Area Executive Team of the Eastern Health & Social Services Board would have visited annually. No records exist to confirm this.

There is a report at LIS13644, which the Inquiry located in the Public Records Office for Northern Ireland, of a visit by members of the Eastern Health & Social Services Board to Lisburn District, including Lissue, on 20th May 1976. If we could look that, please. That's 13644. Sorry. It may be the next page. Yes.

You will see here that it is Lisburn District.

"Report on Visit by Members of the Board and Coopted Members of Committees to Lisburn District on 20th May 1976."

If we scroll down, it says:

"Following lunch at Lagan Valley Hospital, the members visited Lissue Hospital and Killowen Hospital.

Lissue Hospital.

Paediatric Unit.

The members were impressed with the care and attention given by the nursing staff to these young patients. It was, however, apparent that this unit was grossly under-used, but it was understood that this matter was at present under consideration by the Board's officers."

In respect of the Psychiatric Unit it is recorded:

"It was explained to the members that this was the only unit of its kind in Northern Ireland and was used on a regional basis. The members noted the number of patients being cared for and were very interested in the variety of techniques used for teaching purposes. It was, however, felt that the unit was overcrowded and that extra accommodation could be provided if the paediatric unit was closed."

It goes on to note that there was remedial work had commenced for rot at the top of the main staircase.

This shows the Paediatric Unit appears to have been under-used while the Psychiatric Unit was overcrowded. That seems to tally with the figures that we were looking at at LIS12793 a short while ago.

Dr Nelson recalls that the Matron of The Royal Belfast Hospital for Sick Children visited Lissue and there were visits by the Royal College of Psychiatrists

and, after 1983, from the United Kingdom Central Council for Nursing, Midwifery & Health Visiting.

From LIS12755 the bundle contains policies and guidance covering various aspects of nursing care, and includes one from 1986 on seclusion at LIS12757, and the use of restraint from 4th January 1989 at LIS12758, and on the use of time out at LIS12771, which is undated. It is said by the core participants that while these postdate the closure of Lissue, they reflect actual accepted practice.

Prior to the establishment of The Regulatory & Quality Improvement Authority there was no independent body in Northern Ireland responsible for overseeing the operation of any hospital.

Under the terms of the Mental Health (Northern Ireland) Order 1986 a limited role was given to the Mental Health Commission to monitor patient treatment and care accordingly -- and accordingly members of the Commission visited facilities, including Lissue. The Mental Health Commission visited Lissue in January 1987 and the report can be seen at LIS13522 to 13535.

I am going to refer to some parts of the report that cover some of the matters which the Inquiry will wish to consider. If we look at LIS13525, please, you can see that this was a pro forma that was to be completed by

the members of the Commission who were visiting various facilities.

As you will see, this is headed "Treatment plans for patients", but there's a question:

"Does the unit operate a key worker system to coordinate with the individual's programme of care?"

The response to that is given in the larger box to the right-hand side here, which is 1, and the answer then is "Always", but it notes that:

"Key worker is not always medical."

Then if we go to the next page, please, that's 13526, paragraph 8 deals with the issue of pocket money and it says that:

"Pocket money is kept on ward by nurses by ledger card system. It is usually issued daily. There is liaison with patients on this matter and with Social Services, who provide money for children in care. Money is spent on sweets and on outings."

It goes on to note at paragraph 9 that seclusion is never used, and then on the next page, 13527, it notes that there are lockable wards. If we can scroll down:

"Some wards are lockable to keep children out at certain times."

It goes on to say:

"Absconders are catered for by staff reallocation."

Presumably by that it means that some staff have to go to try to find the absconders and other staff are reallocated to look after those who are still in the unit.

At the following page at 13528 the issue of staff training is addressed. It is commented that staff training is satisfactory.

"Nursing staff are given two half-day study sessions. They can also attend weekly training sessions run by the child psychiatrist for medical/nursing staff.

Social workers were given the opportunity to attend training courses."

At 13531 to 13532 the units are described. That's 13531. You will see here that the description of the Psychiatric Unit is given. It says:

"The unit is small, having two seating areas, a dining room, some four-bedded wards and some single rooms. Children are encouraged to bring their possessions and to put up pictures, etc. Many go home alternate weekends; therefore not as much use is made of this facility as might be.

There are two family flats with cooking facilities. These are used in particular for non-accidental injury cases.

A school with four classrooms and five teachers is

attached to the unit and caters for children from 5-13, usually in conjunction with the child's own school.

Recreational facilities include secluded open airplay area and room for indoor activities, such as snooker, darts, etc.

The children were seen at lunch and in school and were happy to talk with us."

"The Paediatric Unit" it is recorded:

"Although we were not scheduled to visit this unit, we took the opportunity to visit the wards. They are used mainly as mental handicap wards and provide important respite facilities. The wards are large, bright and cheerful and there are indoor and outdoor play facilities."

"Assessment and treatment" it is recorded:

"Some of the children are admitted for assessment and stay for a short period only at Lissue. Others are there on a longer term basis for treatment. The average stay is two months; some are less than two weeks; some over one year. The majority are boys."

Then "General Comments" it is recorded:

"The emphasis is on involving the whole family, including parents, siblings, grandparents, uncles and aunts as appropriate. The unit has a closed circuit video unit, which is used to record interviews with

families. One member of the multi-disciplinary team conducts the interview, which can be watched then or later by the others so that a coordinated approach can be planned.

One psychiatrist insists that parents give an undertaking of regular contact and participation on a weekly basis at the least.

The ward records kept for each child are detailed and extensive."

LIS13533, the following page, covers the issues raised by the visit and it says that:

"The Commissioners commented favourably on the multi-disciplinary approach and on the various (sic) harmony between the various professional disciplines.

The only doubt raised concerned the adequacy of staffing in view of the high turnover and high occupancy rates."

There were figures provided to them in advance. Then there were various issues that were raised by staff which related to the role of nursing staff when apprehending absconders and it is recorded that:

"Children do run away from time to time. The doors are not locked. It is hoped to contain such children by maintaining close supervision, but this is not always possible. Nursing staff queried whether it should not

be the responsibility of social workers to look for the children and bring them back. It appears that at present whoever is available is used."

Then the future of the Paediatric Unit was under consideration and similar doubts exist about the future of the school as a result of the potential move of the Paediatric Unit.

Then "Issues to be checked on the next visit" is blank.

We have no other record of visits by the Mental Health Commission either in the bundle of what we have found from PRONI or have been provided.

As regards funding, as a hospital Lissue was funded initially by the Northern Ireland Hospital Authority from revenue received by it from the Ministry of Health and Local Government and then by the Eastern Health & Social Services Board from those monies allocated by The Department of Health & Social Services.

A number of complaints about Lissue have been made to the press, to the police and to the Inquiry. I want to say a little now about media coverage about Lissue.

In October/November 2011 a number of articles appeared in the press when the Stinson report, which had not been published, was leaked to the press. I will say more about the Stinson report shortly.

A few former patients of Lissue spoke to the press and complained about their time in Lissue, and some of the reports from that time can be found at LIS11541 to 11548 in the bundle. Allegations included that staff had confined an anorexic boy to bed when he did not eat and that a staff member had beaten a boy by throwing him against a wall.

In response the Health Committee held two evidence sessions and the then Minister of Health, Mr Edwin Poots, gave evidence to both the Committee and made a statement on the issue to The Assembly in late 2011 and early 2012. I do not propose to go over what was said, but the statements are in the bundle. At LIS10282 to 10296 you can see the Hansard record of the Minister's evidence to the Health, Social Services & Public Safety Committee on 26th November 2011; LIS10403 is the Ministerial statement to The Assembly on 7th November 2011; and LIS10514 to 10553 is the Hansard report on Mr Poots' and others' evidence to the Health, Social Services & Public Safety Committee of 18th January 2012.

Even before this Inquiry was constituted it is clear that it was envisaged that Lissue would be one of the institutions that it would have to look at.

There has been intermittent press coverage about

Lissue and internet postings about it. One press report that made headlines as recently as last Thursday, 31st March 2016, relates to a person who the Inquiry was told did work for a time at Lissue. It was reported that Dr Morris Fraser, a Senior Psychiatric Registrar at The Royal Victoria Children's Guidance Clinic, was able to continue working with children after he had been convicted of child abuse in the 1970s.

The Inquiry has received a statement from Dr McKenna, who was Medical Officer to the Northern Ireland Hospital Authority, which addresses a number of matters, but also speaks to what Dr McKenna recalls about the day he learned about Dr Fraser's conviction at paragraph 10 on LIS703. This was the day that Dr Fraser was due to be the sole interviewee for the post of Consultant Child Psychiatrist in Belfast.

The joint statement provided by the Health & Social Care Board to the Inquiry in February addresses the matter of Dr Fraser at paragraph 144. Can we look at that, please? It is at LIS120. You will see that in response to a question from the Inquiry it is recorded that:

"During their training doctors seeking to specialise in child psychiatry and working towards a consultant's post would almost certainly have spent periods of time

in the Child Psychiatric Unit at Lissue Hospital during its years of operation. It has come to the Board's attention that Dr Roderick Morrison Fraser was a Senior Registrar in The Royal Belfast Hospital for Sick Children and is described as having been employed by The Northern Ireland Hospital Authority as a child psychiatrist from 1st August 1970. Dr Nelson and Dr McAuley recall that as part of his work Dr Fraser would have spent periods at Lissue. The Inquiry may wish to note:

(a) In August 1971 Dr Fraser took a 13-year-old boy that he was involved with through the Scouts to London. The boy subsequently complained that Dr Fraser had indecently assaulted him during this stay.

(b) On 17th May 1972 Dr Fraser pleaded guilty to a charge of indecent assault at Bow Street Magistrates' Court in London.

(c) This was referred to the General Medical Council, where Dr Fraser was found guilty of serious professional misconduct. In determining what sanction to employ the GMC considered the circumstances during sittings ...",

and the dates are given there of July '73, March '74, July '74 and July '75.

"It appears that the matter was subsequently

concluded without sanction.

(d) During this period it is believed that Dr Morris continued to work in Belfast. Recollections from staff at the time suggest that the Northern Ireland Hospital Authority was not aware of the allegation or conviction in 1972.

(e) In or around May 1973 Dr Fraser was charged as one of eight people connected to the abuse of boys on an international scale. This was reported in the local press and came to the attention of the Northern Ireland Hospital Authority on the same day that Dr Fraser was due to interview for a post as Consultant in Child Psychiatry. The interview was cancelled. Dr Fraser did not work with Child Psychiatry in Northern Ireland or at Lissue Hospital following this."

It would appear that Dr Fraser was employed between his conviction in May 1972 and May 1973 when he was charged with offences in New York. He was then suspended from work in Belfast when the Northern Ireland Hospital Authority learned about the matter from local press reports.

The records of the GMC's Disciplinary Committee hearings are at LIS474 to 479. The GMC found that he was guilty of serious professional misconduct in light of his plea of guilty. They then postponed hearing

Dr Fraser's case from 1973 until 1975 on his agreement to undergo psychiatric treatment and heard details of that treatment in camera during that period. Despite the fact that he had pleaded guilty in America in February 1974, the GMC, when they discharged the case against him, appear to have had no regard to that conviction, but only to the offence for which he had been convicted in England.

Press reports from the time indicate that Dr Fraser's counsel argued that his conviction had been "an isolated and squalid act" and relied on the doctor's contribution to peace efforts in Northern Ireland in mitigation. It would appear that Dr Fraser has continued to work in the psychiatric field, but not in paediatric medicine, and, as I have just read, the Inquiry has been told that the consultants who worked in Lissue Psychiatric Unit recall that Dr Fraser spent time at Lissue, but it is important to make clear that none of those who have spoken to the Inquiry about their time in Lissue complain about Dr Fraser, nor is there any complaint about him in the police material.

I now turn to say something about those complaints that have been made by former residents of Lissue either to the authorities or to the Inquiry. Both the Health & Social Care Board and The Department of Health, Social

Services & Public Safety in their statements have provided the Inquiry with details of those complaints that they respectively knew about. I will say something about these shortly, but firstly wish to say what little is known about complaints procedures.

The Northern Ireland Hospital Authority devised a method of dealing with complaints in Circular 72/71 dated 19th May 1971, which was sent to the Management Committee of each hospital, as we can see at LIS12802. At LIS12804 it states that patients or relatives should know how to complain.

We have no information as to what information was given to parents or to children about the right to complain, although a former member of staff told police that there was a meeting with children each morning, when grievances could be aired. The Stinson report sample files suggests that both children and parents did complain on occasion. The Inquiry will wish to consider whether complaints were dealt with appropriately.

For example, if we look at LIS11011 to 11012, this is an extract from the Stinson report and it relates to a girl who was admitted in March 1988 and spent a year in Lissue.

"She was described as being in need of constant and strict supervision and restraint was used on three

occasions. In May 1988 she accused staff of twisting her arm. Staff were spoken to by Nurse L, who was told that her behaviour was unreasonable yesterday and was restrained and twisted her own arm.

On 7th June '88 it is recorded -- an incident occurred which was not recorded in the nursing notes until 12th June '88. While being restrained, Child FF sustained a black eye on 7th June. When mum visited on 9th, she was very annoyed. She was verbally abusive and was spoken to by Mr BB, Mr C and Charge Nurse J. In other notes it is recorded on 7th June '88 verbally abusive and non-compliant and restrained by staff as she was losing control.

A body chart form was completed showing a left black eye."

That was on 8th June.

"On 9th June J spoke to the child's mother and told her that he had had to restrain her. A detailed explanation was given of the restraint used and an explanation given of how the child sustained the injury by the upper part of Nurse J's arm hitting her on the head.

Then at a child protection review on 29th September '88 Mr D described the incident of 7th June thus. An attempt had been made to physically hold Child FF in a

chair to calm her down and in so doing a member of staff accidentally hit her on the eye.

Mr D completed an untoward incident report, in which it was stated Mr BB investigated the matter from the nursing side and was satisfied from the reports from other nursing staff that Nurse J's account was trustworthy."

Then it is recorded on 12th and 13th July that the child would not settle, despite being given several chances to do so, and eventually had to be physically restrained.

Then Mr Stinson records the issues that this incident highlights for him:

"The absence of an independent element to the nursing investigation into the injuries sustained.

There is no information to show that the enquiry considered the reason for the time lag between her injury being sustained on 7th June and the record in the nursing notes made on 12th June, three days later. The child's mother complained on 9th June. There is no information about what prompted Nurse L to complete the body chart form on 8th June.

The family and child care records indicate that the untoward incident report was not completed until 30th June by Mr D. Why was there a delay of 23 days and why

was it completed by Mr D?"

In the bundle at LIS12731 there are minutes of the Royal Belfast Hospital for Sick Children's Medical Staff Committee of July 1968 on the use of Lissue as an In-Patient Child Psychiatric Unit. At that time the need for a separate unit for adolescents was recognised. That can be seen at 12734. Yet we know that Lissue was a mixed age unit, admitting children from babies to age 14 certainly until 29th March 1983, when the incident involving a boy, LS71, came to light.

In March 1983 LS71, who was then in Marmion Children's Home, told his social worker that he did not want to return to Lissue, where he had been resident for five weeks in the autumn of 1982. He disclosed that another boy, who was two years older than him, had sexually abused him in Lissue.

The matter was reported to police and the police papers are in the bundle at LIS31655 to 31690. LIS71 alleged that he was abused in his bedroom at night. The boy against whom the accusation was made, LS72, admitted to police that he had behaved as alleged.

The police outline of the case at LIS31673 indicates that LS8, who is now deceased and who the Inquiry is aware was a nurse at Lissue, could not understand how the offences took place, as there was always someone on

duty at night, and charts that had to be completed were updated at fifteen-minute intervals to monitor sleeping patterns. Although police recommended charging the boy, the DPP determined that a prosecution was not considered appropriate and that decision is at LIS31667.

The steps that Social Services took can be found in a chronology set out in the joint statement at paragraph 82. If we look that, please, it is at LIS098. If we can scroll down, please, to paragraph 82. Although the names are on this, I would just remind people that we do not use the names outside this chamber:

"The Board is aware that in March 1983 a boy alleged buggery by another patient in the Child Psychiatric Unit. The following chronology summarises the steps taken.

The boy was an in-patient in Lissue from 19th August 1982 to 24th September 1982.

He was subsequently placed in Marmion Children's Home. In February 1983 consideration was being given to a further admission to Lissue, which upset the boy. Over the course of discussion with his social worker on 25th and 28th February he disclosed sexual abuse by a peer (whose name he did not know) within the unit during his previous admission.

This matter was immediately reported to police. The social worker accompanied the boy to the police station on 1st March 1983. On that date he was medically examined. It is recorded that, 'The doctor stated that in his opinion (despite the time elapsed since the alleged incident) that sexual interference may have taken place'. The social worker returned to the police station on 2nd March, when a statement of complaint was taken. The Assistant Director of Social Services at the Eastern Health & Social Services Board, Mr Bunting, was also advised of the complaint by telephone on 2nd March 1983.

The allegation was also reported to the Child Administrative Nursing Officer at the Eastern Health & Social Services Board. On 3rd March the Child Administrative Nursing Officer made contact with the District Administrative Nursing Officer, who then undertook an investigation and provided a written reported dated 16th March 1983. The conclusion was, in summary, that policies were sound and there was adequate provision for the nursing care of all children brought into the unit; that an element of risk did exist within the philosophy which had to be accepted; that the recent tendency to admit children over 14 years was stretching the unit beyond that with which it could cope; and that

in completing the investigations the District Administrative Nursing Officer had sought to ensure that nursing staff fully understood their role and responsibilities. The investigation concluded that staff were fully aware of all procedures and there was no indication of any staff negligence. It was held that, given the risk element and the large number of children over 14 years, it was difficult for staff to manage and supervise them and manage their care because of the many difficult need of the various groups.

The report was provided to the Chief Administrative Nursing Officer. Following discussion with consultant medical staff it was agreed to institute a change in policy admission so as to ensure that children over 13 would not be admitted from 29th March 1983. Additionally, measures were taken to re-state all policies and procedures and discussion sessions were held with staff to reinforce their awareness of their roles and responsibility.

By March 1983 the fact of the police investigation had been reported in the press.

On 21st July 1983 The Chief Administrative Officer advised the Department in writing of the untoward incident. This followed correspondence from the Department commencing on 26th March 1983 in light of the

press report. The Department sought information as to which -- as to why the incident had not been dealt with in accordance with the relevant circular", which here is HSS 4 (OS) 1/73, dated 30th October 1973. "The Eastern Health & Social Services Board advised in July 1983 that some confusion had arisen from the fact that this was an allegation being investigated, but accepted that the Department should have been notified, and an apology was given for the oversight.

Matters continued to be followed up to 1985 to secure written confirmation as to the outcome of the police investigation, which culminated in a decision of no prosecution. Mr Bunting also sought details of the alleged perpetrator, as he considered this important in regard to possible risk to other boys. Upon receipt of this information he circulated same to the South Belfast Unit of Management, being the area in which the alleged perpetrator was said to reside."

Now, as is clear from that, the Department felt that the matter ought to have been not... -- they ought to have been notified about this matter. The circular referred to dated 10th October 1973 was not contained in the file that the Inquiry obtained from PRONI and it is unclear what exactly it contained, but while not notified directly by the Board about the case, the

Department were clearly aware of it by July 1983, and they appear to have forgotten this, as according to their statement the first time any allegations about Lissue came to the notice of the Department of Health and Social Services was in December 1986, when the Northern Health & Social Services Board wrote to the Chief Social Work Adviser about LS68.

In November 1986 a girl, LS68, then resident in Coulters Hill Children's Home, informed staff there that she had been sexually abused by a male member of staff when she was resident in Lissue in the mid-1970s. At LIS10048 the untoward incident report dated 19th November 1986 can be seen. LS68 spoke to police and confirmed what she had told the social worker, but refused to make a written statement of complaint. The police papers are in the bundle at LIS31612 to 31654. In January 1987 she made a written statement of withdrawal after police spoke to her again.

At LIS10063 the Director of the Health -- sorry -- The Northern Health & Social Services Board wrote in October 1987 to ask police to carry on the investigation, fearing that other children may be at risk. Accordingly police spoke again to LS68 in February 1988. She said that she was not interested in pursuing the matter.

Police had identified the member of staff against whom the allegation had been made, and he was retired and in ill health and was initially not interviewed. After the matter was reopened police spoke to him in March 1988 and he denied the allegation. No prosecution was directed on 31st March 1988 at LIS31613.

In May 1993, when she was a Social Services Inspector, Dr Hilary Harrison was spoken to by a former resident of Lissue, whom she had known from her time working at Tara Lodge. LS66 was then aged 27, but told Dr Harrison that she had been sexually abused by a male staff member, LS21, at Lissue in the early 1970s. Dr Harrison immediately reported the matter to Dr Kevin McCoy on 27th May 1993, and the report about the allegations is at LIS10076. Dr Harrison relates events at paragraph 17.7 to 17.9 at LIS799 and 800.

The police material relating to LS66's complaints is at LIS3199 -- sorry -- 559 to 31608. In her statement to police she alleged physical and sexual abuse by LS21 and physical abuse by LS78, another employee at Lissue. Both men were interviewed and denied the allegations. A number of members of staff made statements, and the DPP directed no prosecution on 4th October 1993. That is at LIS31564.

After being brought into care in October 1990

another girl, LS67, disclosed that she had been sexually assaulted in Lissue when aged 9 by a male staff member. She was placed in Lissue in June 1986 with her family after having been physically assaulted by her mother's partner. No details of what she said occurred in Lissue. No description or name was ever obtained in 1990, because her parents were reluctant to let her speak about it, as they did not believe her.

The RUC took the view that it was better to allow her social worker to work with her, as she refused to be interviewed by police. Later, while resident in Sharonmore in 1994, she repeated the allegations, and there is a record of that at LIS10118. BAR8, who was a social worker in Barnardo's, told Dr Harrison about this complaint, and she then wrote to ensure that the matter was being pursued by Social Services.

Dr Harrison addresses what steps she took at paragraph 17.10 to paragraph 17.13 at LIS800 to 801.

In 2014 LS67 again contacted the police and a statement of complaint was recorded. It is in the bundle at LIS30401. She alleges that an unnamed male member of night staff sexually abused her in her bed at night on a number of occasions.

In 2008 a further girl, LS69, who was then aged 32, alleged to staff in The Mater Hospital that she had been

abused both in Lissue and in Forster Green when aged 10 -- between the ages of 10 and 16 from 1987 and 1991. She identified six members of staff, including a male member who was still employed in a child care position by the Trust. That's LS79. He was offered alternative work, pending investigation, but went on sick leave and ultimately did not work again, retiring in June 2009.

The police investigation material is at LIS30048 to 30122. There was no prosecution, but an internal investigation was carried out by the Belfast Health & Social Care Trust. The Health & Social Care Board will be providing the Inquiry with an additional statement about the Trust's response to the allegations made about staff in Lissue later this week. There are a number of papers in the bundle relating to these steps, but the Belfast Health & Social Care Trust investigation report is at LIS13694 to 13707.

A review of LS79's staff file can be found at LIS10158 and includes five other complaints from children about his behaviour towards them. Only one of those relates to Lissue. The others relate to Forster Green, and two of those are dated after 1995 and so fall outside the Inquiry's terms of reference.

LS79 was interviewed on 7th October 2008 and denied the allegations that LS69 had made. That's at page 6 of

the report at LIS13700.

The issue is addressed at paragraph 96 of the joint statement on LIS105. The Trust report concluded that the number and overall pattern of alleged incidents raised concerns about LS79's general professional practice over a significant period of time.

We will be looking at what those who have spoken to the Inquiry and who also spoke to police have said when they give evidence. However, some people have complained to police and not to the Inquiry and I want to say a little about those complaints. I do not intend to open up the police material in any detail, but rather give a flavour of the allegations that are made therein.

One case at LIS31692 to 31716 relates to an 8-year-old boy, who was indecently assaulted by a 12-year-old boy, who shared the same bedroom. The DPP directed no prosecution, although a juvenile caution was administered, and police then wrote to the Director of Nursing Services in May 1989 suggesting that supervision at Lissue be reviewed. We can see that letter at LIS31699.

Other statements made to police allege instances of peer sexual abuse, physical and sexual abuse by staff members. They include allegations of indecent assault, gross indecency, buggery and rape, allegations that

staff witnessed physical or sexual abuse or were told about it and did nothing, allegations of over-medication, allegations of excessive restraint, allegations of force feeding, rough treatment and humiliation.

In investigating the allegations, police spoke to a number of former staff members, some against whom allegations were made and others generally about Lissue. Some declined to give statements. Staff members disputed many of the details of the allegations. For example, it was alleged that children were put in padded cells or put in straitjackets. Those who worked in Lissue said that there were no padded cells in Lissue and that straitjackets were never used. Every morning, as I have said, there was a children's meeting at which they could air their grievances. Restraint was used, but staff were taught to remain calm and set an example of good behaviour for the children. Any uneaten food was taken away.

Incidentally, when he was interviewed about the allegations of LS69 in 2008 by those tasked to do the Belfast Health & Social Care Trust interview, LS79 stated that had there were no set rules for managing children's behaviour, that staff were not trained in the use of restraint, and that an inconsistent approach was

taken to its use.

Evidence from staff to police was that difficult behaviour by children was dealt with in a range of ways from loss of privileges, time out, use of a naughty stair, and if a danger to themselves or others, restraining them on the floor or side of the bed.

In October 1981 the BBC broadcast a documentary on the work that was being done by Dr Roger McAuley and his team at Lissue entitled "Horizon: Breaking in Children". The Inquiry has obtained a copy of this and it shows how Lissue worked with two mothers to try to teach them how to deal with their sons' challenging behaviour by means of using time out and reward mechanisms. One family was housed in a self-contained flat in Lissue for a three-week period.

LS79, when he was interviewed by the Trust, stated inter alia that he felt some of the children were not in the appropriate setting and practice was very different then. He said there was not a common approach to the use of restraint, that on occasions he did challenge aspects of the tough regime within the unit, but at that time there were a number of powerful individuals who persisted with the established custom and practice. That comment is at LIS13703.

One of those who spoke to police but declined to

give a statement, a staff nurse, stated that older staff at Lissue would have been harder and stricter than younger staff. The record of that is at LIS31333.

To date no member of staff has been prosecuted as a result of any complaint made about Lissue. Civil claims have been brought by four people in respect of their complaints about their time at Lissue and to date none of these have been concluded.

I should also make it clear that from 2008 a number of people have contributed to comments on Belfast Forum, which is an internet chat forum about Lissue, and stated that they enjoyed their time there. Pages from this are in the bundle at LIS23396 to 23402. It would seem from the content that those who speak about being in Lissue were resident in the Paediatric Unit rather than the Psychiatric Unit.

Chairman, I am now going to go on to examine the cause of all the publicity that arose in 2011, which is the Stinson report, and before we do that I would say something about how it came into existence, but it might be appropriate before going on to what might take a little time to take a short break.

CHAIRMAN: Very well. We will rise for a few minutes.

(11.05 pm)

(Short break)

(11.15 am)

MS SMITH: Chairman, Panel Members, I am now going on to examine the cause of all the publicity that arose in 2011, which is the Stinson report. Before we look at the content of the report I think it important to say how it came into existence.

In 2008, following an investigation into Muckamore Abbey Hospital, the Department asked Health & Social Care Trusts to carry out a wider retrospective review of sample files for both adult and children's mental health and learning disability facilities.

In respect of Lissue the exercise was carried on on a sample of files, which included those who were known to have complained about treatment there, that is the files of LS67, LS66 and LS69, as well as other children named by them and other files that were chosen randomly by computer. Interestingly the files of LS68 and LS71 were not among those selected.

Paragraphs 104 and 105 of the joint statement at LIS109 to 110 outline how the review was undertaken. Bob Stinson was a former social worker and police officer. The Eastern Health & Social Services Board felt that because his report highlighted abuse which was indicative of a harsh regime at the time, it was important to get a professional expert opinion from both

senior nursing and consultants to establish if the behaviour adhered to the standards and practices of the day. That's at LIS10356.

The final draft of the Stinson report is at LIS10973 to 11027. Its remit was to examine case records relating to thirty-four children with a view to identifying safeguarding issues relating to the care of children in both Lissue and Forster Green.

The review's terms of reference and methodology are set out in paragraph 2 of the report. If we look at that, please, that's at LIS10977. It is:

"To conduct an initial sift of thirty children's case files to identify potential areas of concern. The criteria employed at this stage were:

Information suggestive of physical and/or sexual abuse between peers;

By staff;

And information suggestive of:

Grooming activity.

Any information of a harsh regime would also be documented in the sift."

Then phase 2 was to collate that to form a report. Then he describes the methodology that was used. I am not going to go through that, but paragraph 3 at 10978 sets out the definitions that were used in the review.

You will see here that sexual abuse is defined, physical abuse, bullying, harassment, sexual harassment.

Then paragraph 4 is the index to the children and the categories of abuse identified in respect of each. This paragraph 4 runs through from this page to 10984.

Now the names of the children referred to are referred to here by letter, as you will see, Child A, B, C, D and so forth. The names of those children are given on pages 10980 to 10981 -- sorry -- in the following two pages after that. I don't propose to go through the names. Indeed, it would be wrong for me to do so, but I would say that none of the thirty-four names are people who have come to speak to the Inquiry.

The case notes on each child can be found at LIS10785 through to 10964 and details of what was in them can be seen in the appendices to the report at LIS10996 to 11028.

Paragraph 5 at LIS10984, if we could go to that, please, sets out the findings of Mr Stinson. I am now going to look at these in some detail.

5.1:

"This section sets out the findings under the following headings:

Allegations of sexual abuse by peers.

Allegations of sexual abuse against peers.

Allegations of sexual abuse by staff.

Allegations of physical abuse by peers.

Allegations of physical abuse against peers.

Allegations of physical abuse by staff.

Grooming.

Details in relation to children are provided using the reference letter from Table 1. Peer sexual activities are considered under two headings: allegations of sexual abuse by peers and allegations of sexual abuse against peers. The former are allegations made by children while the latter are third party allegations of observations recorded by staff.

Category 1. Allegations of sexual abuse by peers.

The total number of children abused: 8.

Of the 8 cases, 7 related to girls whose ages ranged from 8 to 14 years of age (average age 11). The only boy was 10 years of age. The nature of the allegations ranged from:

Fondling other children, for example, breasts or testicles, on six occasions.

Alleged sexual intercourse: 1

Kissing private parts: 1

Exposing body parts.

Appendix 1 provides details relating to the nature of the incidents detailed in the children's case

records.

Allegations of sexual abuse against peers."

There were six children involved in this category.

"Of the six children -- of the six cases falling within this category, four were boys whose ages ranged from 4" -- sorry -- "9 to 14 (average age 12). Both girls were aged 11. Three children were recorded as touching other children on various parts of their bodies. Two boys were alleged to have had sexual intercourse, one with an 11-year-old girl while in Lissue, and the other with a resident of a children's home prior to admission. In one child's case there were concerns about his sexualised language and knowledge. It was also noted that this 9-year-old was vulnerable to older peers, although the nature of this vulnerability was not specified. He was, however, a frequent absconder with peers.

Appendix 2 provides details relating to the nature of the incidents detailed in the children's case records.

Overall these instances -- incidents demonstrated issues relating to the risks which children presented to one another. The records generally provided little detail regarding how risks were identified, or reported to Social Services and/or police. The result was that

at times it appeared that completing the record was a sufficient action. There was nothing to indicate that records were reviewed by managers who could take an overview across children's files to identify if the mix of children at any given time was of particular concern. There were periods where there was a higher level of absconding, but no information on how the potential to use these absences for untoward behaviours was assessed or addressed. The layout, size and grounds associated with both hospitals and the previous experience of abuse of a number of children presented challenges for supervising vulnerable children. There is no indication how staffing levels took account of either locations or in-patient context. There was at times reference to staff shortage. Such shortage would have had implications for child supervision.

Allegations of sexual abuse by staff."

There were three incidents of this.

"The three allegations within this category related to girls whose ages ranged from 8 to 13 (average age 10). Two of the allegations relate to unnamed staff, while one named a staff member. One of the former and the latter were referred to The Police Service for investigation. In one case, as the 8-year-old could not name the staff member, no outcome was recorded. There

was also no evidence of a review of the case files when the allegation was first made in 1990 to seek to identify any potential untoward event. In the latter case relating to a 13-year-old girl the absence of corroborating evidence when a disclosure was made some fifteen years following her discharge from Lissue meant no police action. The absence of a criminal charge does not, however, obviate the need for consideration at employer level using the balance of probability associated with safeguarding of children.

The remaining allegation related to an 8-year-old girl whose mother alleged that a doll's arm ..."

This would have related to Forster Green in July 1993:

"... and the matter appears to have been resolved to the satisfaction of the parent. However, the records do not specify how.

Appendix 3 provides details on these three incidents.

Allegations of physical abuse by peers.

The file extracts made available contain many references to named children being physically abused or bullied by named or unnamed peers. There is, however, no information to suggest systematic or sustained attacks on any particular child, and what did take place

amounted to spontaneous adolescent brawls, which developed out of some degree of provocation or acts of misplaced bravado.

Allegations of physical abuse against peers.

While the above may also be said about allegations of physical abuse against peers, one child was noted as having committed forty-two assaults on a number of named children.

Overall there was no evidence to suggest that any violence was premeditated. In all cases the records show it was opportunistic and therefore difficult to control. It remains to be seen that there would have been fewer incidents if more staff had been available to undertake supervisory duties. It also must be borne in mind that a large number of the children admitted to Lissue and Forster Green had significant behavioural and conduct disorders, which in many situations made group living difficult for them and others within the group.

Allegations of physical abuse by staff.

Total number of incidents: 2 (recorded in files).
2 (in patients' written statements or transcriptions of conversations with police).

A total of four allegations were made against staff, three of whom were based in Lissue. The other was

a visiting social worker. Three of the allegations were made by girls who ranged in age from 6 to 13 (average age 10). The boy was 12 years of age.

The nature of the allegations included staff allegedly hitting a child, being given 'an awful kick up the behind'. This complainant alleged that two named staff -- members of staff were always violent with the children. The complainant made a written statement to The Police Service in 1993 detailing her allegations.

A further complaint was made to police in 2008 by child J, who alleged physical abuse by teaching and insensitive handling by nursing staff. The complaint regarding the visiting social worker was that a child was grabbed by the arm.

There is no detail on file regarding how these allegations were investigated at the time to ascertain the quality of staff's practice or to inform any changes.

Appendix 4 provides further details."

Scroll down, please.

"Grooming.

In the present context grooming is taken to mean the cultivation of a relationship by a stronger person with a weaker person for some ulterior motive. In the course of this review it was found that older children formed

relationships with younger, more vulnerable children, but no motive was ascertained from the records other than to help staff or to get personal satisfaction. The history of some of the children involved in assisting younger children raises questions about this practice from a management perspective. The Board should check that such practices are no longer extant. Some of the issues which emerged from this practice are set out below under the following headings:

Child/child.

Staff/child.

In almost every file submitted for review there are references to older girls being encouraged to or being allowed to help with the care of younger patients, including help at bath time. Most references are positive. In some cases, however, there are comments which give rise to concern. For example, in one case a patient was recorded as:

"Takes an interest in younger ones. Watchful of staff."

Another note referring to the same patient states:

"... has become involved with younger children. No sexual behaviour observed."

As many of the children admitted to Lissue had experienced significant adverse family situations,

including physical and sexual abuse, the practice of letting them assist with the care of younger children was questionable. Issues arising include was it policy to allow children to be involved in the care of other children? If such were the case, were all children allowed to do this or were some prevented on account of their past or current history? A question also arises as to whether or not children were allowed to care for others because of staff shortages or was it an act of simple humanity? In one child's case it was apparent that she viewed it as another pair of hands and on one occasion when she refused to help, staff comment tended to confirm her perception.

Incidents involving two children, child A and child H, were considered for inclusion in this category, but due to the difficulty in discovering any positive evidence of intent in both cases, they have been included in the staff/child relationships at section 6."

Section -- paragraph 6 here refers to the regime that operated. It deals with a number of matters: restraint, sanctions, victimisation, humiliation, supervision, staffing levels, staff and child relationships.

If we look, first of all, at restraint, it says:

"Restraint is considered in some detail to assess to

what degree it was part of the therapeutic culture of Lissue and Forster Green. Restraints which were clearly used to prevent injury to self or others are not recorded in the cases discussed. A total of six children were the subject of restraint.

The following section considers restraint used in these six children's cases and concludes with a section on the issues arising. Details relating to these cases are available at appendix 5.

The incidents relate to three boys aged from 7 to 12 years of age (average age 10 years) and three girls aged from 11 to 13 (average age 12). Issues arising related to:

Restraint being used when a child threatened or attempted an action rather than posing a risk to self or others.

Involvement of patient's relative, bus driver or student nurses in restraint.

Injury to one -- injury to children. One child sustained a black eye, another friction burns, while one complained of her arm being twisted.

Use of restraint when in pre-admission reports Social Services noted that it was counter-productive, as the child sought any attention, whether positive or negative.

The limited staffing resources which were at times diverted to restraining children and the number of staff employed to restrain individual children.

Restraint used to achieve compliance regarding, for example, refusing to go to time out, or take a shower, or change clothing or bedding.

The length of time for which restraint was employed.

Use of a blanket to restrain a child.

Restraining a child in her bed; particularly of concern with one 11-year-old girl with a previous history of being sexually abused.

Refusing to settle.

In one case there was a delay in recording that a child sustained a black eye until after the mother complained about the injury."

This was the details which we were looking at earlier.

"An untoward incident report to Social Services, who held a Fit Person Order in respect of the child, was dated eighteen days after the event and had to be requested by Social Services. The investigation of the mother's complaint had no independent element, which would have been both possible, given that the child was in care, and desirable. The delay in making this record raises questions regarding the comprehensiveness of file

recording in general.

Issues arising from the use of restraint.

The restraint incidents reviewed as part of this work took place between '88 and '95. It is unclear whether or not there was a policy in place in respect of the application of restraint to guide staff's practice or to monitor practice in this area at that time. While care must be taken to avoid historical events being judged against contemporary standards, there are nevertheless exceptions -- expectations" -- sorry -- "that vulnerable children should be treated with sympathy, respect and understanding and that their dignity should be protected at all times, irrespective of whether or not a policy is in operation. While understanding the difficulties which staff had to face in managing a group of children with complex needs, the following questions emerge:

What guidance, supervision and support had staff access to when employing restraint?

Was it considered appropriate for restraint to be applied for non-compliance?

Was it always applied as a last resort?

Was it always applied in the best interests of the child involved or for the protection of other children or staff?

Were there arrangements for management oversight of its use to inform training or developing other responses?

Were staff appropriately trained and accredited to use restraint?

When it was appropriate, were untoward incident reports completed on time?"

It goes on to say that the 2005 guidance should be brought to the attention and should -- should make sure it has been implemented.

At 6.1.2 he discusses:

"The use of sanctions to influence children's behaviour is acknowledged as one means of influencing acceptable behaviours. In the following the threat of sanctions was used by staff on a small number of occasions to encourage compliance, which impacted negatively on children's contact with important others or the whole group. A total of four children's experiences are considered. Appendix 6 provides a summary of the events.

The four incidents relate to three girls aged from 11-15 (average age 13) and one 7-year-old boy. In two cases children were not permitted a visit home due to failure to comply. One of these was in respect of an anorexic teenage girl who had failed to gain

a kilogram in weight. The other was in relation to a 7-year-old boy with a history of encopresis and nocturnal enuresis. This event occurred when he had spent more than two months away from home. Given his age, sanctions other than restricting his home visits would have appeared more appropriate. The third child for whom denial of leave was used as a sanction was in respect of a child in care, who was refused an overnight stay at her children's home.

In the case of the 13-year-old she was told that unless she provided staff with information on where she allegedly had hidden drugs, other children in the group would not be permitted to go swimming. Such a sanction has the potential to cause hostility between one child and the group. Despite the child's protestations that no drugs were hidden, her room was searched and nothing was found.

In conclusion, given that these children were away from their homes for such a long period, the denial of a home visit as an appropriate form of control to impose for their non-compliance is questioned. There is also no indication of line management's authority being needed to exercise this form of control as staff appeared from the records to be able to not only threaten such action but to ensure that it was followed

through.

Victimisation.

From the information provided it is clear that staff were faced with a wide range of challenging behaviours, some of which were tolerated and some of which were punished with a range of sanctions. Again based on the information provided there was only one boy who was put to bed early as a punishment for a series of misdemeanours.

Without commenting on the merits or otherwise of the boy's complaint, it is unclear what action the night staff took to bring it to the attention of managers or have it resolved.

The exercise of control by the strong or those in authority over the weak or those with no authority, that is by staff over patients, is perhaps one of the most disturbing elements of this review. Children were reduced to their most vulnerable state, that is, having their dignity taken from them by being undressed by staff, or supervised at bath time, or accompanied to the toilet (for unstated reasons) by staff who were strangers to them. While boys were generally subject to this form of control, it was also applied to girls.

The review identified eleven children's cases where humiliation appears to have been used, three boys and

nine girls. The boys ranged in age from 6 to 13 (average age of 9), much younger than the girls, who ranged in age from 4 to 15 (average age 12). With the exception of a 4 and 10-year-old girl the remainder were teenage girls. Details are available of the incidents set out in Appendix 8.

Issues arising fell within the broad categories:

Showering and bathing of older patients, including removal of sanitary towel.

Strip searching.

Insensitivity to symptoms of illness and housing of children.

Standing a child against a wall for one and a half hours.

Forcing a child to bed.

The majority of the incidents included in this section relate to bathing of children. From the records it was unclear how observation was carried out. Did staff remain discreetly, or did they directly observe the bathing/showering process, or did they actually wash children? Was there a different approach dependent on the age and assessed illness of a child? Did children's treatment plan address the need for supervising these activities? Was consideration given to the gender of staff, given the greater number of girls identified as

falling within this category?

Supervision/staffing levels.

The difficulties in providing the level of supervision required by children with complex needs, particularly at Lissue, a large, rambling country house set in a country estate, should not be underestimated, given that there were few restrictions on children's movements throughout the complex.

The review examined the records of children cared for over a period extending from 1979 to 1995. Thirteen children were noted as needing varying levels of supervision over this period, but they were not all in residence at the same time. It is, therefore, not possible to detect retrospectively any sustained period of children requiring supervision at the same time not getting the care they needed. However, the notes made on individual children provide an indication of the concerns felt by nursing staff and the impact on children may be assessed by the level of misbehaviour and gratuitous violence noted during the review of their case records. Further details are provided at appendix 9.

The following addresses issues relating to staffing and supervision levels from the four cases within this category. Two girls aged 10 and 13 and two boys aged 9

and 14 were identified by staff as requiring higher levels of supervision than staffing levels permitted. The implication for the supervision of children in their care are evident from these records, which may not fully reflect the position, given that only a small sample of cases was reviewed.

Apart from being noted on the files was any recognition given by management to the concerns raised by staff in 1979 and '80 regarding staffing levels? When one considers the high level of restraint used at times, which took up considerable staffing resources, and the complexity of children's needs, the staffing complement needs to be given particular attention when considering the overall findings of this review.

There is no record on the case files of a response from the Director of Nursing to Dr A's letter.

Were the staffing levels at Lissue and Forster Green at a level to provide the required level of supervision, given that staffing levels were raised over a period of years?

Staff/child relationships.

There were two girls aged 8 and 14 about whom the records suggested issues relating to the appropriateness of the staff/child relationship (see appendix 10). These are set out below in some detail. There is no

indication of management oversight of case files, which potentially would have brought the potential risks associated with the situations to the attention of the staff member so that safer practices could be promoted to minimise the risk of complaint.

The need for management oversight of records as a tool to monitor practice is not evident in these cases or in others. Neither is there any sense that comments such as those recorded in respect of an 8-year-old child were subject to closer scrutiny. The practice in the case of a 14-year-old girl of undertaking therapeutic work on a longer practitioner basis in her bedroom late at night is also one which managers should have reviewed to assess how safer practices could have been employed to protect both the staff and the patient."

He then goes on to discuss in detail child J and it says:

"A separate section has been provided in respect of this child, as she was an adult who made a complaint about her treatment at Lissue."

He goes on to say that she was first admitted when she was 12, and at 33 she described her treatment in Lissue to police and the details are given in Appendix 11.

"They should be considered with caution, as at this

time it amounts to a series of uncorroborated allegations, but the general issues arising from her case are given here. It is said that her interview with police alleged an institution at Lissue and Forster Green run on the basis of threat, the installation of fear among vulnerable children, the deliberate deprivation of their dignity and bullying by senior staff. While I have cautioned about the need for corroboration, a significant number of issues raised by child J also emerges from the review of the file notes submitted as a basis for this review. The Board and Belfast Trust should take action to ensure that current practice in in-patient adolescent facilities is to a high professional standard and all staff are trained on child protection matters."

At paragraph 7 he records the conclusions formed and makes recommendations. I am not going to go through the rest of the report reading it, but I will read his conclusion here at paragraph 7.1, and he says:

"Matters of professional concerns in respect of the care of children at both units have been identified over the period reviewed. The nature of these concerns will require the Board and its Trusts to ensure that further action is taken as necessary where the police or professional assessors determine breaches in either

legislation or professional codes of practice. The author is conscious of the wider context of:

"Children admitted to Lissue with their range of complex and at times competing needs.

"The challenges arising from the structure of the institutions and a risk of judging practice by today's standards."

Now if we quickly scan through the appendices to the report, we can see that Appendices 1 and 2 cover details of the peer sexual abuse. That's at LIS10996 to 11002. Appendix 3 details the allegations of sexual abuse by staff at LIS11003 to 11007. Appendix 4 details allegations of physical abuse by staff at 11008. Appendix 5 covers the issue of restraint. That's at 11009 to 11012. Appendix 6 details the sanctions used at 11013. Now Appendix 7 is missing and we have checked with the Health & Social Care Board, who have been unable to locate it. We are not quite sure what Appendix 7 might have covered. Appendix 8 covers humiliation at 11014 to 11018, and Appendix 9 covers the details of supervision in Lissue at 11019. Appendix 10 gives details from the cases sampled about staff/child relationships. That's at 11012. Appendix 11 is a summary of the main issues highlighted in the ABE interview of child J, who is LS69. That's at 11022 to

11027.

Now the Stinson report was to consider what child safeguarding issues were identified by examining those thirty-four files, and when the report was presented to the Eastern Health & Social Services Board, it determined that it ought to be considered from the medical and nursing perspective.

Maura Devlin, who was the Director of Nursing and Midwifery Education, was tasked to consider the standard of nursing care provided in Lissue in the 1975 to 1995 period. She did this by sampling just four files and by considering the findings of the Stinson review.

Her report is at LIS11082 to 11092, and essentially states that the standard fell below acceptable standards on many occasions. If we look, please, at LIS11090, at paragraph 4.1.3 here she says:

"It is recognised that there is little merit in assessing the practice of nurses managing challenging behaviour twenty years ago against today's standards. Much has changed in this area of practice and today's practitioners are supported and guided with a much greater range of bespoke education and policy guidance.

During the period of review it is evident from the records examined that patients' behaviours provoked nursing responses which were punitive in nature, such as

the use of restraint or sanctions. While it is acknowledged that this was accepted practice at that time, there is evidence that even within this context some nursing practice moved beyond the boundaries of reasonableness. Examples include the withdrawal of permission for family contact or home leave, withholding food and the strip searching of adolescents.

The use of restraint did on occasions result in injury without follow-up, treatment or assessment, and nursing notes refer to one patient being dragged. This falls outside the standards for professional practice as laid down by the UKCC at the time."

At paragraph 4.2 she discusses a member of staff who she -- whose name is given here. I just remind you again that name isn't to be given. That is LS79. I think I have got the right designation. She says that there is sufficient suggestion in the limited records to warrant further investigation in respect of his behaviour.

A summary of the complaints made to -- in the Stinson and Devlin reports to named nursing staff can be seen at LIS11093 through to 11096.

Now Marion Reynolds, who was then Deputy Director of Social Services, prepared an interim report in July 2009 summarising the key findings. It is at LIS11101 to

11109. If we look, please, at 11108, we can see her concluding remarks. If we just scroll down, she says:

"The children admitted to Lissue had a range of their complex and at times competing needs, which meant that staff had a challenging task trying to care for them. The structure and layout of the institutions added to the complexities of the staff's tasks. In reaching conclusions it is important also to ensure that practice is not judged unfairly against today's standards.

Matters of professional concerns in respect of the care of children at both units have, however, been identified over the period reviewed. The review found high levels of peer abusive behaviours and a regime that was at times harsh and punitive. There are also instances of staff care of children which gave rise to concern. Three allegations were made to the police, of which two were investigated. In respect of one no corroborating evidence meant the case could not be progressed. On the balance of probability it is, however, likely that her complaint had a basis. The 2008 complaint by another is now being considered by the PPS.

The PSNI has confirmed that in relation to the children's abusive behaviours it is unlikely that any

further action can be taken due to both the children's age at the time of the incidents and also as many of the allegations are now statute-barred."

She just goes on with her conclusions there.

The Jacobs report commenting on the psychiatric standards at the time is at LIS11110 to 11122. Now he was asked to comment on whether the services provided by the child psychiatrists at Lissue and Forster Green were adequate in light of subsequent complaints detailed in the Stinson report. I don't propose to go through it in detail. Instead I will highlight some of the comments he makes. The Inquiry will no doubt wish to hear the views of Dr Nelson and Dr McAuley when they give evidence next week.

At LIS11112 at paragraph 2.1.5 Mr Jacobs makes the point that LS75 or 79 -- I am not quite sure of the designation -- placed himself in a vulnerable position with regard to a child, but that in 1986 a male nurse putting a female child to bed was not exceptional.

At paragraph 2.7 at 11114 he poses the question whether staff had raised with management issues of staffing and the suitability of Lissue as a facility, stating that:

"To manage children that are described in this report high levels of staffing and appropriate

facilities are absolutely necessary, otherwise it is unsafe for children and for the staff."

Paragraph 3.1, he refers to Stinson's observations on peer sexual abuse and poses the question whether there was a pressure for management to keep beds filled.

At 3.4 he speaks about the undesirability of having wards that mix age groups, but again states that this practice was not uncommon in the early 1980s.

His overall conclusions are at LIS11120. Again I don't intend to read them all, but if we look, please, at paragraph 9, if we can scroll down to paragraph 9, in these paragraphs he identifies what are essentially systems issues and of interest to this Inquiry. In paragraph 9 it should be:

"Mr Stinson raises the issues of the suitability of the buildings and the staffing at each unit. I would completely agree. My experience of in-patient psychiatric work" -- sorry -- "psychiatry -- child psychiatry work is that managers and commissioners need to grasp that it is the child mental health equivalent of the intensive care unit in medicine. Throughput is much slower, but real and lasting change can be made for children and young person that is not achievable in the complex cases that are admitted on an out-patient basis.

Reading the case histories that were supplied and

other documents available to me, I was struck that the two in-patient psychiatric services were being used at times for children and young people who were proving too difficult to manage in a Social Services setting. This is not the job of an In-Patient Psychiatric Unit in my view and that of most in-patient consultants. It is very easy to be pushed into the position of accepting such children by senior management, but it is a mistake. They are not -- they are usually not unwell. Often they quickly resent being in a psychiatric setting. They show this through aggression and other delinquent acts. Sometimes, even though they are unwell, for example, from depression, they are so conduct disordered that they require a secure setting that cannot be provided safely in the context of an open child or adolescent psychiatric ward. It was my impression that other children who would normally be manageable were becoming less so because of the behaviour of others and insufficient resources to manage the situation."

At paragraph 12 he says that he has:

"... been asked specifically to address whether the services provided by the child psychiatrists were adequate in light of subsequent complaints detailed in the report."

He says:

"After carefully sifting the partial information available to me, I think the service they provided was clinically good."

But he goes on to say:

"I think that they were part of a failing system that was not of their making and that they probably had limited opportunity to effect change. I have seen no documents that suggest that the units were adequately resourced for the tasks they were being asked to undertake."

The Stinson report dated January 2009, the Devlin report from May 2009, the Jacobs report of February 2010, together with Marion Reynolds' interim report for the Health & Social Services Board, a quality assurance report and a commentary on the adequacy of the psychiatric services available in Lissue and Forster Green were all provided to the Department in March 2010.

Also Detective Inspector Reuben Black wrote to Marion Reynolds in May 2009 about police action in respect of any criminal offences disclosed by the Stinson report. That letter is at 11969.

Dr Harrison states at paragraph 22.7 of her statement at LIS804 that the Department did not consider that the reviews had been carried out in a consistent way and suggested that a further investigation or review

should be considered.

According to the joint statement at paragraph 108, LIS110 to 111, Margaret Burke and Geraldine Sweeney did this on behalf of the Belfast Trust for Lissue. They looked at ten files from the 1970s, which was the period not covered by the Stinson review. The report can be found in the bundle at LIS10738 to 10762. It analyses the files to identify child protection concerns and in respect of the files for Lissue patients from the 1970s it identifies a number of issues, not all of which relate to Lissue.

If we look at LIS10750, in discussing the record management systems and recording, it says:

"A number of issues were identified.

In some instances there was a lack of written evidence of what action was taken following the identification of child protection concerns. It is unclear from the files if this was due to a lack of awareness in relation to risk assessment processes, relevant child protection procedures and thresholds for referral to Family and Child Care Social Services, or if it was due to poor record-keeping. In the period 1970-1979, while there might have been a lack of understanding in relation to some forms of abuse, there would have been an expectation that alleged physical

abuse would have been referred to Family and Child Care Social Services. However, in six files reviewed relating to this period there were instances -- incidents of alleged physical abuse recorded in the in-patient files and no evidence of these being reported to Child and Family Care -- Family and Child Care Social Services.

Ian McMaster, Charles Bamford and Maurice Devine provided a report entitled "Retrospective Sampling Exercise: Professional Comments on Reports" in May 2010. It is in the bundle at 11124 to 11153, and it clearly deals with all the retrospective reviews that the Department had sought.

In conclusion they state that any random sampling exercise has fundamental weaknesses and does not equate to a full and comprehensive review. They say that at 11151.

It is clear that both the Stinson report and the Burke-Sweeney review covered a random selection of files, just forty-four of the possible 1124 children who were treated in Lissue Psychiatric Unit as in-patients between 1971 and 1989. The Inquiry may wonder what an examination of all files might have revealed.

Both Dr Harrison and the joint statement speak about the Strategic Management Group that was set up in

response to the media coverage in late 2011 covering allegations of abuse in Lissue and Forster Green Hospitals. Dr Harrison speaks about it at LIS804 from paragraphs 22.8 to 22.18, and the joint statement refers to it at LIS111 from paragraphs 111 to 113 and exhibits the final report from December 2013 at LIS391 to 460.

The aim of the Strategic Management Group was inter alia to assure the Department that where incidents of alleged abuse were identified in the retrospective sampling reports, any issues or concerns in relation to individuals who were able to be identified through the files had or have been dealt with appropriately. Any possible crimes were referred to police and any staff and regulatory issues were addressed by the appropriate trust or employer. The process concluded in July of 2014.

Before finishing, Chairman, as has become the practice in counsel's opening remarks, I want to thank again all those who have helped to prepare for this module. I include in my thanks representatives of the core participants, who I know struggle at times to meet the challenging deadlines set by the Inquiry in order to fulfil its statutory obligation, but my primary thanks goes to the Inquiry teams, legal and administrative, who work behind the scenes, and while I dislike singling out

anyone, as all who work in the Inquiry contribute enormously to our work, I would say that in preparation for today Miss Maria Dougan, Miss Jennifer Kirkwood, Miss Carla Irvine and Miss Jane McManus have worked tirelessly and I know will continue to do so throughout this fortnight. So I thank them particularly.

Chairman, Panel Members, ladies and gentlemen, that concludes my opening remarks for Module 13. We will start to hear evidence tomorrow.

CHAIRMAN: Thank you very much. Well, we will rise now and we resume at the usual time tomorrow morning.

(12.10 pm)

(Inquiry adjourned until 10 o'clock tomorrow morning)

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I N D E X