DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

STATEMENT TO THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 13

LISSUE CHILDREN'S HOSPITAL

25 March 2016

I, Hilary R Harrison will say as follows:

This statement has been provided on behalf of the Department of Health, Social Services and Public Safety (the Department) in response to the Rule 9 request of the Historical Institutional Abuse Inquiry (HIAI) dated 16 December 2015. It has been prepared on the basis of information contained in files currently held by the Department and such evidence received from the HIAI as it has been possible to review within the required timeframe. As further information becomes available, it may be necessary to provide to the HIAI, revised or supplementary statements.

Question1

1. When did Lissue open and during what period did it operate?

1.1 The Department understands that Lissue House, a private home, was opened in May 1947 for the treatment and convalescence of sick children. Following a brief period of closure after the ending of the war in 1945, Lissue House was privately donated to the newly created Northern Ireland Hospitals Authority (the Authority). It re-opened in 1949 as Lissue Hospital, a paediatric medical and surgical hospital and continued as such until May 1971, when it began to provide additional services in the form of psychiatric in-patient and day patient services for children and young people. In later years, prior to its closure, Lissue hospital also provided in-patient respite care for children with complex health needs.

1.2 The Health and Social Care Board (HSC Board) in its statement to the HIAI dated 29 February 2016[1] (the HSC Board statement) has set out in detail the history and operation of the hospital with reference to the Child Psychiatry Unit, until the service transferred to the Foster Green Hospital site, Belfast. Attached at Annex A of this statement is a comprehensive history of the hospital and all paediatric services provided on the Lissue site from the hospital's opening to its closure in January 1989 taken from a book written by a former consultant paediatrician at the hospital. entitled: 'A history of the Royal Belfast Hospital for Sick Children: a history 1948-1998'[2].

2. How many individuals spent time in Lissue?

2.1 The HSC Board statement provides the numbers of in-patient and day patient between May 1971 and 29 February 1989[3] to the psychiatric unit at Lissue. During these years 1,124 children were admitted as in-patients and 250

[1] LIS 079
[2] Love, H. The Royal Belfast Hospital for Sick Children: a History 1948-1998. Belfast: Blackstaff Press, 1998
[3] LIS 081

children were admitted as day patients.

2.2 More general statistics for the whole of Lissue hospital are available from annual statistics published by the DHSS between the years 1966 to 1989 which show total inpatient admissions of between 201 and 501 children per year and between 290 and 1760 day patient attendances annually (Annex B).

3. On what basis were children admitted to Lissue?

3.1 The HSC Board statement sets out in detail the general clinical framework under which *"24 hour intensive treatment"* services were provided. Whilst admission criteria were not precisely defined, the hospital's range of methodologies and admission patterns indicate that children who were admitted to the Child Psychiatry Unit were those with the most complex mental health and behavioural needs. These included emotional and behavioural disturbances and psychiatric illnesses, which in addition to more traditional methods, were addressed through the provision of alternative treatment approaches such as behavioural modification programmes, family therapy and child management skills for parents.

3.2 With reference to the other medical, surgical and respite care paediatric services provided on the Lissue site, the Department does not have any further information other than that contained in the contained in the history of Lissue at Annex A.

4. What legislation governed the operation of Lissue?

4.1 Lissue was governed by the provisions of the following primary legislation in so far as its operation as a hospital was concerned:

- The Health Services Act (NI) 1948 (the 1948 Act);
- The Health Services Act (NI) 1971(the 1971 Act);
- The Health and Personal Social Services (Northern Ireland) Order 1972 (the1972 Order).

5. What rules, regulations or Orders (legislative or otherwise) applied to Lissue?

5.1 The Department has been unable to identify any subordinate legislation that addresses the management and operational questions with which the HIAI is concerned in relation to Lissue. The HSC Board's statement, however, includes written policies and guidance[4] which established the procedures and

[4] LIS 084

approaches to be taken in the management and care of children and child patients. The HSC Board understands that although these post-dated the closure of Lissue, they reflect what was already accepted practice within the hospital. The Department has no reason to dissent from this view.

6. Who regulated Lissue and what approach was taken to regulation?

6.1 In so far as the concept of 'regulation' in its broadest sense relates to the control and governing of the conduct of a hospital, there was, prior to the establishment of the Regulatory and Quality Improvement Authority (RQIA), no independent body responsible in Northern Ireland for the 'regulation' of hospitals. The Mental Health Commission established by section 20 of the Mental Health (NI) Order 1986 (the 1986 Order) (see paragraph 7.3) had a limited role in seeking to monitor patient treatment and care. However, the 1948 Act and subsequently the 1972 Order which established the legal framework in which Lissue was directed and controlled, placed a range of powers and duties by the Ministry of Health and Local Government (MHLG) on the administering bodies established to ensure the proper and effective running of the hospital. The 1948 Act provided for the establishment of the Authority which was a body corporate consisting of a Chairman and Vice-Chairman appointed by the MHLG Minister and such other persons as the Minister saw fit, which included the membership as prescribed within Part II of the First Schedule to the 1948 Act[5]. Under the 1948 Act the Authority was responsible for the development, co-ordination and over-all control of the Hospital and specialist services but the duty of administering services provided at or in connection with hospitals was entrusted to Hospitals Management Committees (Committee/s). The Committees were responsible for the day to day running of hospitals under a General Scheme and a Management Scheme made by the Authority and in this matter acted as acted as the Authority's Agents.

6.2 The 1972 Order established Health and Social Services Boards (HSC Boards) to exercise on behalf of the Ministry of Health and Social Services (subsequently, the DHSS) the functions relating to the requirement in the 1972 Order for DHSS to provide hospitals and their necessary medical, nursing and other services. HSC Boards were also required to submit for approval by the DHSS a scheme for the exercise of these functions. As in the case of the Authority, each HSC Board consisted of a Chairman and Vice-Chairman appointed by the DHSS Minister and such other persons as the Minister saw fit, which included the membership as prescribed within the 1972

[5] The 1948 Act provided that the Authority would be constituted by order – this was done by the Health Services (Constitution of the Northern Ireland Hospitals Authority) Order (NI) 1948 which listed all the members of the Authority by name – S.R. & O 1948 No. 81

Order.

6.3 In addition, the HSC Board statement has pointed out that medical and nursing staff were registered and regulated by their respective professional bodies[6].

7. Who inspected Lissue on behalf of the regulator and when? Please provide copies of any inspection reports

7.1 The power to inspect hospitals was afforded to the MHLG and subsequently the DHSS under section 63 of the 1948 Act, section 70 of the 1971 Act and Article 50 of the 1972 Order.

7.2 The Department presently has no information to indicate whether this power was ever exercised by the MHLG or the DHSS other than by means of a Social Services Inspectorate (SSI) led inspection of services for disabled children in hospital, the report of which, 'Care at its Best' was published in 2005 (Annex C). This inspection considered the care of disabled children in a range of hospital settings, including the Foster Green Child Psychiatry Unit and the Adolescent Psychiatric Unit, then based at College Green, Belfast and made a number of recommendations regarding the inpatient care of such children.

7.3 The HSC Board statement makes reference to the role of the Mental Health Commission (the Commission), established by the 1986 Order. Whilst an inspection role *per se* was not conferred on the Commission by the 1986 Order, many of the duties and powers afforded to it were similar to that of an inspection body. These were subsumed under a general duty on the Commission under Article 86 "*to keep under review the care and treatment of patients..*" Specific duties identified in Article 86(2) included *inter alia* the duty to inquire into any case where it appeared to the Commission that there may be ill-treatment, deficiency in care or treatment and to bring to the attention of various authorities, including the DHSS and the relevant Health and Social Services Board the facts of the case in order to secure the welfare of any patient. Article 86 (3) of the 1986 Order empowered the Commission *inter alia* to: refer to the Review Tribunal[7] any patient who was liable to be detained in hospital; visit, interview and medically examine in private any patient; and inspect any records relating to the detention or treatment of any patient.

[6] LIS 086

[7] The Mental Health Review Tribunal is an independent judicial body set up under the 1986 Order to review the cases of patients who are compulsorily detained or are subject to guardianship under the Order.

7.4 The HSC Board has provided evidence to the HIAI to the effect that a visit was made by two members of the Commission to Lissue Hospital in or around January 1987 as part of an intended programme of annual visits to each hospital by the Commission[8]. A subsequent report (undated) by one of the visiting members of the Commission indicated that the Commission "*commented favourably on the multi-disciplinary approach and on the obvious 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."*[9] Further reports are not available, but as the HSC statement has noted, the child psychiatry in-patient service moved from the Lissue site in 1989.

8. What were the governance arrangements for Lissue?

8.1 In so far as the term 'governance' relates to the structures and processes for ensuring that the hospital provided quality of care, paragraphs 6.1-6.3 above and the HSC Board statement have set out in detail the hospital management and administrative structures established by the 1948 Act and the 1972 Order and the responsibilities of the various administering bodies. Within these structures, the HSC Board statement has noted that a committee within the Royal Belfast Hospital for Sick Children (RBHSC) also governed the Lissue Hospital. The RBHSC committee was responsible to the Belfast Hospital Management Committee, which in turn reported to the Authority.

8.2 From October 1973, Lissue Hospital came under control of the EHSSB. The HSC Board statement explains the management and reporting structures that were in place on the implementation of the 1972 Order. The HSC Board statement explains that on a day-to-day basis Lissue was a Consultant led unit.

8.3 The Department has no further information to add to the HSC Board's response to this question save to note that the Authority was responsible for the discharge of its functions to the MHLG and not to the Ministry of Home Affairs as suggested by the HSC Board statement.

9. Was there a Management or Visiting Board and how was it comprised?

9.1 Apart from the information presented in paragraph 8.1 above regarding the RBHSC Committee and the Belfast Committee, the Department has no further information presently to hand regarding whether each hospital had a visiting Board. The HSC Board statement has noted that the Belfast Committee

[8] LIS 088
[9] LIS 088

appeared to have appointed a visiting team, one of whom was allocated to Lissue Hospital. Whilst no reports of such visits have been found, the Department has no reason to dissent from the HSC Board's belief that the hospital was visited by the Belfast Committee (or indeed by the RBHSC Committees) and the Matron in charge of the RBHSC as well as representatives from the Royal College of Psychiatrists and the Central Council for Nursing, Midwifery and Health Visiting.

10. How was Lissue funded?

10.1 The Authority received revenue funding from the MHLG. The Authority was responsible for allocating this to its various Hospital Management Committees. From 1973 Lissue was funded by the Eastern Health and Social Services Board out of monies allocated by the DHSS.

11. What were the staffing arrangements?

11.1 Please refer to the detailed information provided by the HSC Board in relation to this question.

12. Was there any vetting of staff?

12.1 Checks were made with registering bodies for doctor or nurse appointments at Lissue. With reference to social workers employed at the hospital, from 1981, criminal records checks were made by HSC Boards with the DHSS Pre-Employment Consultancy Service for all such appointments. The HSC Board has also advised that appointments would have been made in accordance with DHSS guidance and procedures regarding the appointment of health services staff.

13. What records were kept in Lissue?

13.1 Please refer to the detailed information provided by the HSC Board in relation to this question.

14. Was any form of physical chastisement permitted in Lissue?

a) What form did physical chastisement take?
b) Under what circumstances was it administered?
c) By whom?
d) How was it recorded?
e) To whom was it reported

14.1 Please see paragraph 19.1 below.

15. Was any other form of discipline employed in Lissue, if so, what form did this take?

15.1 Please see paragraph 19.1 below.

16. Is the Department aware of any contemporaneous complaints made of abuse in Lissue?

16.1 The Department does not have any information to hand which suggests that the MHLG or subsequently the DHSS were aware of any contemporaneous complaints in relation to the Lissue Hospital.

17. Is the Department now aware of any complaints of abuse at Lissue between its opening in 1946 and is closure in the early 1990s and when were those allegations first known?

17.1 The Department was aware of the following complaints in relation to alleged sexual abuse by staff at Lissue:

The LS 68 complaint made in November 1986 relating to the mid 1970s

17.2 To the Department's knowledge this was the first complaint brought to the attention of the DHSS in relation to Lissue. It was made in November 1986 by a young woman, LS 68, then aged 17 years and resident in Coulter's Hill Children's Home, a home run by the Northern Health and Social Services Board (NHSSB).

17.3 The Chief Social Work Adviser (CSWA) was notified by letter dated 22 December 1986[10] from the Northern Health and Social Services Board (NHSSB), that a girl then aged 17 years who was in the care of the Board had alleged she had been sexually assaulted by a male member of staff at Lissue when she was a patient in the hospital some 10 years previously. The NHSSB had notified the EHSSB who in turn had referred the matter to Lisburn RUC. The EHSSB appears to have ascertained that that the person against whom the allegation had been made was a nurse who had left the service a year previously on the grounds of ill-health. The DHSS made a written request dated 8 January 1987[11] to the NHSSB to be kept informed and requested a further update from the NHSSB on 24 March1987[12]. By letter dated 14 April 1987[13] the NHSSB responded indicating that AB refused to make a formal statement of complaint to the police but that the EHSSB was inquiring further

[10] LIS10050
[11] LIS10051
[12] LIS 10055
[13] LIS 10057

into the matter.

17.4 On the advice of the EHSSB by letter dated 27 October 1987[14], the NHSSB challenged a police decision communicated to Lisburn Social Services on 8 April 1987[15], not to pursue the matter any further as LS 68 had made a written statement in January 1987 withdrawing the original complaint. As a consequence, the police confirmed to the NHSSB in November 1987 that the investigations were being reopened and that the findings would be submitted to the Director of Public prosecutions[16]. The CSWA (now the Chief Inspector, SSI) was copied into correspondence between the NHSSB, the EHSSB and the police in relation to these events and requested by letter dated 7 December 1987 to be kept informed of any further developments[17]. The Department does not hold any additional information in relation to this case.

17.5 The Department holds no further information regarding the LS 68 complaint.

17.6 The following information regarding the LS 66 and LS 67 complaints has been drawn from documentation which was shared with the EHSSB by the DHSS, which was retained by the Board and submitted in its evidence to the HIAI. The DHSS's own file in relation to these complaints is not available, having most likely been disposed of in accordance with the Departmental file management systems.

The LS 66 complaint made in 1993 relating to the 1970s

17.7 In May 1993 during my tenure as a DHSS Social Services Inspector, LS 66, then a 27 year old woman and a former resident of Barnardo's Tara Lodge Adolescent Unit which I had previously managed, alleged to me that while she had been a patient in Lissue some 14 years previously, she had been sexually assaulted by a male nurse whom she named. I provided a report on the matter to Dr K McCoy, the then Chief Inspector (CI) and Mr N Chambers, an SSI Assistant Chief Inspector (ACI)[18]. I recall that the contents of the report were discussed with me at a meeting between the CI, the ACI, the then Assistant Secretary within the DHSS's Child Care Policy Branch, Mr J Kearney.

17.8 Following the meeting, I contacted Sergeant W McAuley of the RUC Care Unit on behalf of LS 66 I understand Mr P Simpson, a senior official within the DHSS Management Executive contacted the EHSSB and the Green Park

[14] LIS 10063
[15] LIS 10056
[16] LIS 10065
[17] LIS 10067
[18] LIS 10076

Trust, where the member of staff was then working as a nurse in the Foster Green Child Psychiatry Unit. He was temporarily suspended and a police investigation ensued. I understand no charges were preferred due to lack of corroborating evidence.

17.9 At the time of the [redacted] complaint, I was not aware of the previous complaint made by [redacted] in November 1986, which also had been reported to the DHSS. I did not become aware of this complaint until very recently when the Departmental files relating to Lissue, which had been had copied to the HIAI were provided to me to read.

The [redacted] complaint made in 1994 relating to June-August 1986

17.10 On 18 December 1994, I was informed by telephone by BAR 8, a social worker employed by Barnardo's and attached to the Sharonmore Project that a young girl resident who had formerly been a patient in Lissue had alleged she had been sexually assaulted by a male member of staff. The DHSS had not yet received any formal notification of this but in view of my knowledge of the [redacted] complaint, I wrote by letter dated 19 December 1994[19] to the Barnardo's Assistant Divisional Director responsible for the Project, Mrs L McClure, seeking assurance that the allegations were being pursued with Social Services and that Social Services would also be made aware of the recent police investigation into similar allegations led by Sgt McAuley[20].

17.11 By memo dated 4 January 1995[21], the ACI wrote to Mr P Simpson of the DHSS Management Executive to advise him of the situation. Mrs McClure (Barnardo's) confirmed by letter dated 5 January 1995 that the relevant HSS Trust was pursuing the current [redacted] allegation and was liaising with the RUC in relation to the previous allegation[22].

17.12 According to a letter dated 7 August 1996[23] from Mr J Veitch (Family and Child Care Services Manager, South Eastern Trust) to the RUC that [redacted] allegations made in December 1994 could not be pursued because of her refusal to be interviewed by the police. She was further interviewed by a social worker from the Trust in August 1996 by confirmed that she did not wish the matter to be pursued. I note that I wrote by letter dated 2 October 1996[24] to Mr Veitch in which I refer to pursuing a matter with the RUC, seemingly of an original statement of complaint made by [redacted] in 1990 which I perhaps had not

[19] LIS 10115
[20] LIS 307
[21] LIS 10116
[22] LIS 10117
[23] LIS 10118
[24] LIS 10119

been aware of in 1994. I see from internal RUC correspondence that I also spoke to D/S McAuley[25] and D/C Ferguson[26] in October 1996. I cannot recall why I was involved in such discussion at this stage, but I undertook to keep Mr Veitch informed.

17.13 In January 1997, I wrote to Detective Chief Inspector Cardew of the RUC outlining the circumstances of the LS 66 and LS 67 complaints[27]. I cannot recall why I initiated this correspondence, as internal DHSS correspondence is not available but from the contents of the letter I can see that I had some concern that that information from the 1990 LS 67 complaint had not been linked to the LS 66 complaint. DCI Cardew responded to me by letter dated 14 February 1997[28] enclosing copies of internal RUC correspondence relating to the RUC's handling of the complaints[29]. I responded to him in June 1997, having just returned from a period of 3 months sick leave. I can see from the correspondence that the RUC were unable to pursue matters any further in view of LS 67 refusal to speak to the police.

The 2001 complaint by unknown former resident of Sharonmore, Barnardos which emerged during the 'Macedon' Police Inquiry

17.14 In May 2001, I was contacted by D/S Jeff Boyce lead officer in the Macedon investigation. He was seeking information about my knowledge of allegations of sexual abuse at Lissue hospital. I understood from our discussion that a further woman, then 30 years old and a former resident of Macedon unconnected with LS 66 and LS 67 had made similar allegations. I was not given the name of the woman concerned but provided D/S Boyce with the information I had from my records. I informed the then CI by minute dated 4 May 2001[30] of the conversation and the information shared. I do not believe I was contacted again in relation to this matter.

The LS 69 complaint made in 2008 relating to events in Lissue/Foster green Hospital 1985-1991

17.15 In May 2008 the Department received a 'Serious Adverse Incident Report' (SAI)[31] from the Belfast Health and Social Care Trust to stating that a service user then aged 33 years, had identified the names of 6 staff whom she alleged had been involved in abusing her while she was a patient during the

[25] LIS 10089
[26] LIS 10087
[27] HIA 10082
[28] LIS 10084
[29] LIS 10085-10089
[30] LIS 10090
[31] LIS 10125

above years. I believe the SAI was discussed with me by Norma Downey (Child Care Policy Directorate) and we considered the relevant information from the Departmental file that should be provided to alert the Trust and the PSNI to the previously known allegations. By letter dated 12 May 2008[32] all relevant documentation held by the Department was sent to the Trust and requesting that the Department be kept informed of developments. As a consequence, following a strategy discussion in July, the EHSSB agreed a range of actions, one of which was to conduct at the request of the Department, a review of Lissue childrens' and staff files. This became known as the 'Stinson Review', the process for which has been comprehensively described in the statement by the HSC Board[33].

18. What steps were taken by the Department in relation to complaints between 1946 and the closure of Lissue in the early 1990s?

18.1 Please see the response to the preceding question 17 which sets out the steps Department took on receipt of each of the above complaints.

19. The Inquiry has received a number complaints about specific matters and wishes to know the following in relation to the years between 1946 and the closure of Lissue in the early 1990s:

a) How did Lissue deal with those children who wet the bed?
b) What chores were children expected to engage in, were chores ever given as a punishment?
c) Were children provided with cigarettes? In what circumstances?
d) Was bullying condoned, if not how was it dealt with?
e) How were children supervised at night?
f) Were children physically restrained at night? If so, in what circumstances?
g) Were children isolated, if so, in what circumstances?

19.1 These issues together with those identified in the questions posed by the HIAI at paragraphs 14 and 15 above, were all operational matters for the Lissue Hospital. Concerns about practice in these areas would have first come to the attention of the Hospital Management Committee, the Authority or from 1973 onwards, the EHSSB. The MHLG and DHSS would not have had knowledge of matters such as this unless a complaint or concerns had been formally raised with either the Minister or MHLG/DHSS officials. The Department has no information to suggest that this happened.

[32] LIS 10226
[33] LIS 107-111

20. The Inquiry is aware that there was a school on site, by whom was it regulated and inspected?

20.1 The school at Lissue[34] was established by the South Eastern Education and Library Board and was subject to periodic inspection by the then Northern Ireland Department for Education's Inspectorate.

21. The Inquiry is aware that a television documentary was made in relation to Lissue. Please provide a copy of the same.

21.1 The Department believes that the above request refers to a BBC 2 Horizon production entitled "Breaking in Children", broadcast on 12 October 1981 and featuring the work of a consultant child psychiatrist based at the Royal Victoria Hospital and Lissue Children's Hospital. The Department does not have a copy of the documentary but has referred the HIAI to sources from which it may be obtained.

22. The Inquiry is aware that a historical review was carried out into Child Safeguarding Issues (the Stinson Review). How was that review received and were any steps taken by the Department on receipt of the same?

22.1 The steps taken by the Department on receipt of the Stinson Review need to be viewed in the context of other major work undertaken by the Department, Boards and Trusts to identify potential cases of historical abuse against children and adults mental health and learning disability hospitals. The Stinson Review contributed to the Department's strategy in taking this forward.

22.2 In 2005, a former patient in Muckamore Abbey Hospital made a complaint alleging sexual abuse some 30 years earlier. That complaint was exhaustively investigated in a process that was commissioned by what was then the EHSSB and which involved the police, including professionally-monitored interviews with patients and the scrutiny of almost 300 files of patients who had been in Muckamore Abbey. There were no prosecutions arising from this investigation.

22.3 Following this exercise, which was largely into the abuse of patients by other patients, the Department asked HSC Trusts to conduct a wider retrospective sampling exercise across adults' and children's files from all Mental Health (MH) and Learning Disability (LD) hospitals across NI (covering the period 1985-2005). This was in order to determine whether there was any evidence

[34] See page 130 of Annex A which provides details of the school.

of historical abuse of patients.

22.4 The aim of the retrospective sampling exercise was to explore a sample from the other LD and MH facilities in order to:

- determine whether there was any evidence that similar incidents were common elsewhere; and

- seek an assurance from the HSC Board and HSC Trusts that appropriate procedures were now in place to prevent abuse of children and vulnerable adults in such facilities, and that any such incidents of abuse identified were dealt with properly and effectively.

22.5 HSC Trusts carried out this exercise, at the request of the Department, during 2008-09. The brief for the retrospective sampling exercise was to focus on those people most at risk, especially minors (children under the age of 18 years) admitted to MH and LD hospitals between 1985 and 2005. A 10% sample of relevant files was agreed.

22.6 The exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital, where a similar exercise had already been carried out) and regional child and adolescent inpatient mental health services.

22.7 When Departmental professional advisers and policy colleagues examined how this exercise had been carried out, they concluded that Trusts' approaches and coverage had not been consistent, and therefore the Department required further assurance regarding the rigour of the exercise. It was suggested that a further investigation or review should be considered, particularly in relation to the findings for certain settings.

22.8 In late 2011, there was extensive media coverage of abuse allegations in Lissue and Forster Green Hospitals resulting from a leaked memo from the HSC Board to the Press. The Health Committee held two evidence sessions in relation to the allegations reported in the media, in October 2011 and January 2012. Former Minister Poots made a statement to the Health Committee on 26 October 2011, and to the Assembly on 7 November 2011, and a further statement to the Health Committee on 18 January 2012. The Health Committee asked to be kept updated on developments.

22.9 A Strategic Management Group (SMG) co-chaired by the HSC Board and the PSNI, was established in March 2012. The remit of the SMG was to review the 2008/09 retrospective sampling exercise, and identify concerns or issues arising from the reports conducted by the EHSSB into Lissue and Forster

Green Hospitals, and consider actions taken at the time. It was agreed that all cases in which abuse was suspected would be referred to PSNI for potential criminal investigation.

22.10 The final SMG report into the review of the retrospective sampling exercise was received by the Department in December 2013. Departmental officials met with the HSC Board in March and August 2014, highlighting a number of queries with the report and seeking further assurances on a number of issues in the SMG report. In addition, the HSC Board held a further meeting with the PSNI in June 2014 to seek clarification on some of the issues raised by the Department.

22.11 The key findings of the SMG report are summarised as follows:

(i) Where it had been possible to identify the victim or the alleged perpetrator, details of potentially criminal activity had been passed to the PSNI for investigation.

(ii) There was inconsistency across Trusts on sample size, timeframes, and recording and analysis of findings.

(iii) It was difficult for SMG to determine whether actions taken at the time were in accordance with extant standards, as all policies and guidance were not available.

(iv) Some records had been destroyed in accordance with record management guidance.

(v) The PSNI had identified a number of challenges including de-criminalisation of some offences since that time *(for example, consensual sex between adults of the same gender);* absence of identifiers, including names, of alleged victims or perpetrators in records; the fact that a number of incidents are statute barred; and the destruction of some patient records.

(vi) There had been no prosecutions to date as a result of the retrospective sampling exercise or the review of the exercise.

22.12 With regard to the destruction of records referred to at point (iv) above, the schedule for the management and destruction of records includes clear timescales for the destruction of records. The HSCB instructed Trusts not to destroy records likely to be required for the Historic Institutional Abuse Inquiry (HIAI) once the HIAI was established. However some relevant records may have been destroyed in accordance with the guidance prior to this instruction

being issued.

22.13 The following information was provided to the Department by the HSC Board in relation to incidents referred to the PSNI with reference to children. This included the information gained from the Stinson Review:

- 35 incidents were referred to the PSNI
- 25 were closed by PSNI following review of papers
- 10 were referred to District Public Protection Units for investigation of which 4 related to one potential victim and were subject to on-going PSNI investigation, which had not yet concluded; and 6 fell outside the scope of the review. The incidents relate to contextual concerns prior to the young people's admission to the facility. The PSNI were following up the issues and social services are no longer involved.

22.14 There have therefore, been no prosecutions to date as a result of the retrospective sampling exercise or the review of the exercise.

22.15 Within the children's sub-group, there were four incidents of alleged abuse by staff. In two cases, the allegations were investigated by HSC Trusts and PSNI under the relevant protocols for the Investigation of cases of Alleged or Suspected Cases of Abuse of Children/Vulnerable Adults, but no further action taken. In one case the staff member was no longer employed by the Trust. At the request of the SMG, the Trust reviewed the relevant documentation and no further action was required. In one case, the staff member was referred to the relevant regulatory body and HSC Trust HR procedures. These further investigations concluded that no further action was required.

22.16 The SMG report gave assurance to the Department that, where incidents of alleged abuse were noted in the retrospective sampling reports:

- any issues or concerns in relation to individuals who were able to be identified through the files have been actioned appropriately, either at the time of the original incident; as a result of the retrospective sampling exercise; or as a result of the SMG review process;

- any criminal concerns or issues have been referred to PSNI; and

- any Human Resources and regulatory issues have been taken forward by the appropriate Trust or employer.

22.17 The HSC Board has further assured the Department that where an alleged perpetrator continues to receive in-patient care from the Trust, appropriate steps have been taken to reduce the risk of any harm to other service users. Those patients who are living in the community and are in contact with mental health services receive regular assessment of their health and social care needs including assessment of any potential risk they pose to themselves or others. In addition, the HSC Board assured the Department that any concerns identified which fell outside the scope of the exercise are being investigated in the appropriate way.

22.18 The HSC Board in July 2014 confirmed that the process had concluded (Annex D). The PSNI also confirmed in September 2014 that the aims and objectives of the retrospective sampling process have been achieved and that the Strategic Management Group had achieved its function and could be formally stood down (Annex E).

23. What systems failures, if any, relating to the HIA Inquiry's Terms of Reference that you can identify *(sic)* from the material.

23.1 In its review of the information provided in support of this statement the Department is unable to identify any systemic failure on its part in relation to the Lissue Hospital.

24. Any other relevant information you wish to make the Inquiry aware of in respect of Lissue

24.1 The Department has no further information to offer at this stage.

Signed

Date **25 March 2016**

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

STATEMENT TO THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 13

LISSUE CHILDREN'S HOSPITAL

SUPPLEMENTARY STATEMENT

8 April 2016

I, Hilary R Harrison will say as follows:

This statement has been provided on behalf of the Department of Health, Social Services and Public Safety (the Department) to supplement the information contained in the Departmental statement to the Historical Institutional Abuse Inquiry (HIAI) on Lissue Children's Hospital dated 25 March 2016 (the March 2016 statement). It has been prepared as a consequence of information which has just come to light regarding systems previously established by the Department to monitor and evaluate standards of care within hospitals in Northern Ireland. The statement also includes reference to a further allegation of abuse which, according to the statement made by the Health and Social Care Board (HSCB) in respect of Lissue, was made known to the Department of Health and Social Services (DHSS) in March 1983.

1. Paragraphs 7.0-7.4 of the March 2016 statement

Who inspected Lissue on behalf of the regulator and when? Please provide copies of any inspection reports

Supplementary Information

1.1 The March 2016 statement states *"the power to inspect hospitals was afforded to the MHLG and subsequently the DHSS under section 63 of the 1948 Act, section 70 of the 1971 Act and Article 50 of the 1972 Order"*[1]. It is important to note that the power to inspect under Article 50 was a general power relating to the accommodation of persons under arrangements made by the Ministry and whilst this included hospitals it was not a provision that related only or specifically to hospitals.

1.2 In October 1984, the DHSS established the Northern Ireland Hospital Advisory Service (NIHAS) (Annex A). In summary, the role of NIHAS was to help maintain and improve the organisation of patient care (excluding matters of clinical judgement) in long stay hospitals and hospital units for the elderly, the mentally handicapped, the mentally ill and the young chronic sick and to *"make such recommendations to the Department and to Boards as it considers appropriate"*[2]. The functions of NIHAS[3], included:

- the provision of advice on the promotion of high standards of patient care[4]; and

[1] Paragraph 7.1 of the March 2016 statement
[2] Annex A, paragraph 3
[3] Annex A, paragraphs 3-5
[4] Annex A, paragraph 4.1

- discussion of issues of patient care with hospital staff. Opportunities for discussion could be provided during visits or by means of conferences or seminars arranged by NIHAS[5].

1.3 The core membership of NIHAS was nominated by the Minister. Reports of hospital visits made by NIHAS were to be sent to the Minister through the Permanent Secretary of the DHSS and to the relevant Health and Social Services Board through the Chief Administrative Officer in his capacity as Secretary to the Board[6]. Although NIHAS did not carry out 'inspection' as such, its objectives and monitoring functions were not dissimilar to that of an inspection body. With regard to the latter, the work of NIHAS was *"not to detract from the monitoring function of Boards"*[7].

1.4 NIHAS was stood down when the Northern Ireland Guidelines and Audit Implementation Network (GAIN) was formed in 2007 by the amalgamation of the Clinical Resource Efficiency Support Team (CREST) with the Regional Multi-professional Audit Group (RMAG) and the Northern Ireland Audit Advisory Committee (NIAAC) to form a single clinical and social care regional audit and guidelines body for Northern Ireland. GAIN is responsible for commissioning regional audits and disseminating audit results and from 2015 has been located within the Northern Ireland Regulation and Quality Improvement Authority.

1.5 The Department does not presently have access to information indicating whether NIHAS visited and reported on Lissue. Whilst a Departmental search has revealed that approximately 150 files relating to NIHAS existed, the vast majority of these have been destroyed. Only three of the files that were not destroyed and that may possibly (although it is doubtful) contain information relevant to the Lissue Hospital are listed as having been retained by PRONI[8].

2. Paragraphs 16.0-16.1of the March 2016 statement

Is the Department aware of any contemporaneous complaints made of abuse in Lissue?

Supplementary Information

2.1 The Department has noted the reference in the HSCB's statement to correspondence between the Eastern Health and Social Services Board

[5] Annex A, paragraph 4.5
[6] Annex A, paragraphs 8-9
[7] Annex A, paragraphs 8-9
[8] These are BP/3037/95 entitled "NIHAS Reports" ; BC/1118/92 entitled Policy on NIHAS Review 1990; and BP/902/81 entitled Northern Ireland Hospital Advisory Service.

(EHSSB) and the DHSS regarding a contemporaneous allegation of peer abuse made by a patient in Lissue in 1983[9]. The Department notes that correspondence took place between the DHSS and the EHSSB in March 1983 following a media report of the resulting police investigation. The HSC has reported that the DHSS sought information as to why the incident had not been dealt with in accordance with circular HSS 4 (OS) 1/73, dated 30 October 1973) (Annex B). The EHSSB apparently advised in July 1983 that some confusion had arisen from the fact this that this was an allegation being investigated, but accepted that the DHSS should have been notified and an apology was given for the oversight.

2.2 The Department does not have any information about this incident in records currently available. It has also been unable to locate within the HIAI Lissue evidence bundle, the 1983 DHSS and EHSSB correspondence to which the HSCB statement refers.

3. Paragraph 12.1 of the March 2016 statement

Was there any vetting of staff?

Corrigendum

3.1 Please note, this paragraph states *"With reference to social workers employed at the hospital, from 1981, criminal records checks were made by HSC Boards with the DHSS Pre-Employment Consultancy Service for all such appointments"*. The year in which the DHSS Pre-Employment Consultancy Service came into effect was 1983 and not 1981.

Signed

Date **8 April 2016**

[9] LIS 098-100

LIS-1414

MINISTRY OF HEALTH AND SOCIAL SERVICES
HSS4(OS) Branch
Dundonald House Upper Newtownards Road Belfast BT4 3SF
Telex 74578 Telephone 0232 (Belfast) 650111 ext

Please reply to The Secretary
Your reference

The Chief Administrative Officer of
each Health and Social Services Board

Our reference A1034/73
Circular Ref No HSS4(OS) 1/7
Date 30 October 1973

Dear Sir

NOTIFICATION OF UNTOWARD EVENTS IN PSYCHIATRIC AND SPECIAL CARE HOSPITALS

1. I am writing to draw your attention to a long-standing administrative arrangement whereby the Northern Ireland Hospitals Authority undertook to notify the Ministry of the details of all untoward events involving patients in psychiatric or special care hospitals. Untoward events include

a) unauthorised absences;

b) accidents; and

c) sudden, unexpected or unnatural deaths.

2. It is essential that this practice be continued. Each Health and Soci Services Board should therefore arrange for a telephone message to be sent HSS4(OS) Branch, Dundonald House, Upper Newtownards Road, Belfast BT4 3SF, (telephone Belfast 650111 extension 397) as soon as possible after the occu of any such untoward event, with the following information:

a) the nature of the occurrence (ie whether an unauthorised absence, a accident or a sudden, unexpected or unnatural death);

b) a brief description of the circumstances of the event;

c) the name of the patientinvolved and his hospital status;

d) the name of the hospital of which he was an in-patient and if the incident occurred in any place other than that hospital, the locati of the event;

e) the date and time of the occurrence; and

f) whether the patient's relatives, the RUC and the Ministry of Home Affairs, as appropriate, have been informed of the event.

3. To enable the necessary information to be furnished to the Ministry, e Health and Social Services Board should ask the psychiatric and special car hospitals within its area to notify the Board by telephone, in the first pl of the details of an untoward event immediately its occurrence becomes know Immediate notification is particularly important where a death has occurred

Yours faithfully

Fionnuala McAndrew
Director of Social Care and Children

Email: Fionnuala.mcandrew@hscni.net

9th March 2011

Dr Maura Briscoe
Director of Mental Health and Disbility
DHSSPS
Room D4.14
Castle Buildings
Stormont Estate
Belfast BT4 3SQ

Personal Social Services
Health and Social Care Board
12 – 22 Linenhall Street
Belfast
BT2 8BS
Tel : 028 9055 3964
Fax : 028 9055 3620
Web Site :
www.hscboard.hscni.net

Dear Maura,

RE: RETROSPECTIVE SAMPLING

Please find attached a report into the review of a sample of cases of children who were admitted to Lissue and Foster Green Hospitals. You are aware from previous communications that the HSCB has liaised with the Belfast Trust and PSNI on these matters and PSNI has confirmed that no further action will be taken in relation to the allegations they have investigated.

The review reports have been shared with the Belfast Trust. there were 16 recommendations and 12 conclusions contained within the three professional review reports commissioned by the HSCB and there was some overlap in their findings. I have written to the Belfast Trust to require further reassurance in respect of three of these as follows:

Process for Monitoring Abscondings

The Trust should confirm that it has robust policies for monitoring and assessing abscondings from its current in patient facility and for independent de-briefing of young people on their return.

Use of Regional Restraint Guidelines

The Trust should confirm that its restraint policies and procedures are compliant with the DHSSPS Guidance on the use of Restraint and Seclusion (2005).

Care Plans

The Trust to confirm that young people's care plans are person centred.

All other recommendations have been either:

- Actioned by HSCB as a result of the review reports
- Actioned by Belfast Trust and contained within the action plan provided as a result of their retrospective sampling exercise. DHSSPS is in receipt of this report and action plan. the HSCB requested an update of progress on this action plan on 19 November 2010 and the Trust reported that all but one of the actions had been completed and the remainder was being progressed.
- Incorporated into policy and guidance issued since these events took place
- Reviewed within both the QNIC audits and the recent RQIA review of CAMHS, the latter incorporating child protection arrangements specifically.

In making their recommendations, all three reports highlight the need to consider the findings in the context of practice at the time and it is clear that some practices that were common place would not be tolerated today. It is also important to recognise that current inpatient and residential accommodation for children and young people is open to more external scrutiny than in the past. However, 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. Specific concerns were identified in relation to some individual staff members and I am satisfied that these have been appropriately addressed.

I would also like to confirm that the Health and Social Care Board was made aware of the findings of this exercise at the confidential Board meeting held on 25 November 2010.

Finally, I would like to apologise for the delay in finalising this report to you. As you are aware the work was commenced by the legacy EHSSB. The final review report relating to medical practice was commissioned by the new HSCB. On receipt this identified new concerns which were shared with PSNI, and there was an administrative delay in receiving their confirmation of no further action.

However, I hope that you will find that the EHSSB instituted a robust sampling exercise but if you have any further queries then please contact me.

Yours sincerely

Fionnuala McAndrew
Director of Social Care and Children

Enc

RETROSPECTIVE SAMPLING OF CASES IN BELFAST TRUST/ SAI 117-08

INTERIM REPORT TO DHSSPS

Introduction

The legacy EHSSB received a Serious Adverse Incident Report from Belfast Trust in May 2008. This related to an internal review being conducted by the Trust in respect of allegations of abuse at Lissue and Forster Green between 1985 and 1991. As the EHSSB was directly accountable for service provision on both sites during this period, it led on an investigation of the historic aspects of the alleged abuse.

Independent reports

The legacy EHSSB commissioned a series of reviews in respect of professional practice at Lissue and Forster Green which are outlined below.

RS Stinson, Social Services Manager, SET (retired), File review, January 2009.

M Devlin, Director of Nursing and Midwifery Education, Beeches Management Centre, Review of the Standard of Nursing Care, May 2009.

Dr B Jacobs, Consultant Child and Adolescent Psychiatrist, South London and Maudsley NHS Foundation Trust, 'Independent Child, Psychiatry Comment on report by RS Stinson', February 2010.

In addition the Board is in receipt of the report of the Belfast Trust 'Retrospective Child Protection and Safeguarding Audit within Regional Child and Adolescent Inpatient Service' and their action plan.

It is understood that a number of allegations have been considered by PSNI. Further information was passed to PSNI following receipt of Dr Jacobs report and a strategy group meeting in April 2010.

On 17th September 2010 the Board received confirmation from PSNI that no further action is anticipated and that they consider the case closed.

Staffing Issues

The children admitted to these facilities had complex and challenging needs and the layout of the institutions added to the staffs challenges in caring for them. It is important to ensure that the practice at the time is judged by the standards of the day.

However, there were three staff members named in the Stinson report and require consideration.

Staff 1: no allegations were made against this staff member. No concerns have been expressed by previous employers or staff members. The person remains in employment and there have been no reasons for concern.

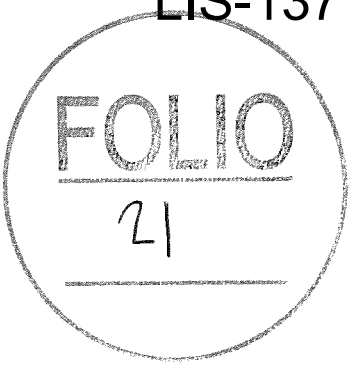
Staff 2: disciplinary procedures were initiated against this staff member who denied all allegations. The person was made redundant from their employment with the Belfast Trust who refuses to act as a referee. A vetting and barring referral was made by the Trust. It has been confirmed that nursing registration has lapsed.

Staff 3: this person retired from the service in 1996. It is understood that he/she was interviewed by PSNI but that no prosecution has ensued.

Next steps

The Board considers that it is now in a position to make recommendations on this matter to DHSSPS. These will be considered by the Board at their meeting on 25th November 2010. A report will be issued to DHSSPS thereafter. This will include an action plan to supplement that prepared by the Belfast Trust.

Fionnuala McAndrew
October 2010



For Noting

Health and Social Care Board

Report in respect of Historic Review of Children admitted to Lissue and Forster Green Hospitals

Introduction

This report sets out the findings of a review of the care and treatment of children admitted to Lissue and Forster Green Hospitals in the late 1980's.

The review was instigated by the legacy Eastern Health and Social Services Board following receipt of a Serious Adverse Incident report on 2 May 2008.

The report includes a summary of a parallel audit undertaken by the Belfast Health and Social Care Trust to ensure that current safeguarding arrangements within the regional inpatient child and adolescent facility are robust.

Background

Lissue and Forster Green Hospitals were directly managed services within the Eastern Health and Social Services Board with the establishment of Trusts in 1994. The hospitals provided inpatient care for children with a range of mental health difficulties including anorexia, depressive illness, suicidal and self harming behaviours and a range of conduct and behavioural problems.

The service was at that time Consultant led and two Consultant Psychiatrists provided support from the Child Psychiatry Unit based on the Royal Victoria Hospital site. Lissue Hospital ceased operation as a Child Psychiatry Unit in 1991.

Incident Report

An allegation was made by a previous resident at Lissue regarding her care and was notified to the EHSSB as a Serious Adverse Incident in May 2008. The Belfast Trust advised that it was undertaking an internal review in respect of allegations made about staff previously employed at Lissue and Forster Green Hospitals between 1986 and 1991. The allegations related to physical, mental and sexual abuse.

The DHSSPS was aware of 2 previous allegations made in 1993 and 1994 and in receipt of the SAI brought this to the attention of the Belfast Trust and EHSSB to assist with their investigations.

The EHSSB historic review of records sought to determine the nature and extent of any abusive behaviours at the units and was augmented by work lead by both Belfast and South Eastern Trust.

Methodology of the Review

The EHSSB commissioned an independent review of 34 records of children admitted to the units to identify any concerns. This was followed by two further independent reviews to look at clinical practice at the time. The EHSSB and Belfast Trust worked closely with PSNI who investigated the complaints and considered the findings of the reports as they identified any potential criminal activity.

Independent Review Reports

An initial report was provided by an Independent Social Work consultant following a review of 34 case files. The findings of this review indicated that there were matters of professional concern at both units. The review found high levels of peer abuse and a regime which was at times harsh and punitive. There were also instances of staff care that gave rise for concern.

Three allegations of abuse were made through PSNI of which two were investigated. One case was referred to the Public Prosecution Services and the Board is not yet aware of their decision.

A second review was undertaken by an Independent Nurse Consultant and the report was received in May 2009. This provided an overview of the standard of nursing care at Lissue and Forster Green based on the first independent review report and an examination of a further 4 case files.

The review found that there was a lack of appropriate care planning and planned responses to children and adolescents engaged in sexualised behaviours or bullying.

The lack of procedures and protocols aimed at promoting the safe management of relationships resulted in children and staff being placed in vulnerable situations.

Examples of practice from the case notes indicate a harsh and punitive regime which promoted authoritarian control of nurses over children.

There was little evidence of multi disciplinary working and the use of restraint was clearly referenced in case files.

The review drew attention to the conduct of a named member of staff which is addressed later in this report.

The third review was undertaken by an Independent Consultant in Child and Adolescent Psychiatry who works within the NHS in England. This report was received in February 2010 and provided a commentary on the initial review report and notes and records were made available including notes at ward rounds.

This report highlighted new information from the case notes in relation to abuse of children by other children. This new information was forwarded to PSNI who responded in September 2010 advising that their contact with the children identified has not resulted in a complaint and they did not intend to proceed in this matter.

This report concluded that the service provided by the medical staff was clinically good, however, there were a range of factors that mitigated against providing appropriate and adequate care to the children at that time.