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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 Tuesday, 12th April 2016

commencing at 10.00 am

(Day 200)

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

Tuesday, 12th April 2016

(10.00 am)

DR HILARY HARRISON (called)

CHAIRMAN: Good morning, ladies and gentlemen. Can I, as always, remind everyone to ensure if you have a mobile phone, it's been turned off or placed on "Silent"/"Vibrate", and I remind you also that no photography is permitted either here in the chamber or anywhere on the Inquiry premises.

Good morning, Ms Smith.

Questions from COUNSEL TO THE INQUIRY

MS SMITH: Good morning, Chairman, Panel Members, ladies and gentlemen. Our first witness today on what is Day 200 of our public hearings is a regular in this chamber and that's Dr Hilary Harrison on behalf of the Department of Health, Social Services & Public Safety.

Dr Harrison's statement is at LIS791 to 964, which includes exhibits, and there is a short addendum statement at 1406 is 1414. Dr Harrison has, of course, been sworn previously.

Dr Harrison, as in previous modules, you can take it that the Panel and Inquiry have read the entirety of your statement and the exhibits thereto.

I think when we were having a discussion that from that it would appear that, unlike perhaps other

institutions that the Inquiry has looked at, in respect of Lissue the role played by the Department was somewhat different in that here the role was largely to provide funds to initially the Northern Ireland Hospital Authority and then subsequently the Health & Social Services Board, the Eastern Health & Social Services Board, from which they allocated monies to run Lissue and employed staff and really had overall governance for that institution. Would that be correct?

A. Yes. That's correct.

Q. Now I'm just going to look at a couple of things. We see from the work that the Inquiry has done that there was an allegation of peer abuse in 1983 and the Department complained they weren't informed about that. The joint statement that the Inquiry has received on behalf of the Health & Social Care Board, which I am sure you have seen --

A. Yes, I have.

Q. -- talks about the 1973 circular and you attach that to your addendum statement at 1414. Maybe if we just briefly look at that. I am pulling this up because although it was talked about, we have not actually looked at it before. It is noted -- it is a letter essentially from Dundonald House, Ministry of Health and Social Services, to the Chief Administrative Officer of

each Health & Social Services Board. It says:

"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."

Then it sets out how those untoward events should be reported.

"The Health & Social Services Boards should ask psychiatric and special care hospitals to notify the Board by telephone in the first place of details of an untoward event immediately its occurrence becomes known."

Now on one view of that it could be argued that, well, an incident of peer abuse might not fall into those three categories outlined, although it quite clearly says "includes the following".

A. Yes.

Q. Yet equally on another view when we are looking at -- we

are looking at -- it is addressing incidents where harm occurs, injury or unexplained absences or death. So, therefore, an incident of peer abuse would fall into that broader umbrella of harm that ought to have been reported.

A. Yes, I would agree.

Q. I mean, when we were talking, you were explaining to me that certainly it was part of the general consciousness in the '70s and '80s that if there was anything that might cause concern to the public, then that ought to be reported to the Department so that they were aware, particularly in light of matters coming to press attention, which is exactly what happened in 1983. The first the Department seemed to know about it was when it did come into -- there was a report in local press about it.

A. Yes.

Q. Isn't that right?

A. Yes.

Q. You were saying that there was no equivalent to this 1973 circular sent on the social care side to children's homes or to the boards about children's homes. Is that correct?

A. Yes. I can't find any trace of that, but I'm certainly aware from my own practice in the 1970s and early '80s

that where any event happened that was likely to be a matter of concern, public concern in relation to the care of children, whether those children were in institutional care or in foster care, or indeed on the child protection register, that the Department was to be immediately notified. That was part, as you say, of our consciousness in working in Social Services during those decades.

Q. The 1983 incident of peer abuse had a further significance, might I suggest, in that we are aware from Module 5 when we looked at Harberton House and Fort James about the whole incident of peer abuse that occurred in that -- those institutions and the response that there was, but that was in the '80s that that came to light, early '90s. This was 1983, some -- not quite a decade but certainly a good half decade before that. This was an incident of it being in the public consciousness at that time that children could behave in this way. Isn't that right?

A. Yes, that's right, yes.

Q. And certainly was known to the Board and was known to the Department, belatedly perhaps, but certainly was known. So is it -- might -- was this, do you think -- and I know we are speculating, because we don't have any documentation -- but was this, do you think, seen as

a one-off?

A. I think it may have been, because to our knowledge that is the first report of peer abuse within an institution. The next one that we can trace came in 1985 and that was sexual -- peer sexual activity in Tara Lodge, Barnardo's, between older teenagers, but really the first -- the first incidents of peer abuse amongst younger children, apart from the 1983, one was the 1989 incident in -- incidents that were the 1989 incidents in Harberton House, as a result of which you will know there was --

Q. Yes.

A. -- significant activity by the Department.

Q. Yes. We looked at those in Module 5 and I don't propose to go back to that. It is interesting that this was an incident of young children engaged in this activity. There was a two-year age gap between the two boys concerned.

A. Yes.

Q. Going back to your main statement, you talk in paragraph 17 about those complaints which the Department did know about. If we can go to that, that's page 798. At 17.2 there you say:

"To the Department's knowledge the complaint of LS 68, who is LS68, "was the first complaint brought to the

attention of the DHSS in relation to Lissue. It was made in November '86 ..."

Now just in respect of that we were talking earlier and, I mean, this -- 1986 is post-Hughes. The whole issue of sexual abuse of children in institutions has come on to the radar since the whole Kincora scandal. The landscape has changed, but is it likely that not only because of that, but because of the fall-out from 1983 and the Department not being informed, that the Board were more keen to report such incidents to the Department, do you think?

A. I'm sure that was part of the reason it was reported, but also it was significant in that the allegation was against a member of staff, and to our knowledge whilst I know now that it wasn't the first allegation known to the Department, because I wasn't aware when I was writing the statement of the 1983 peer abuse one, but it appears to have been the first indication of an allegation of abuse by staff in England.

Q. Part of the reason I ask this is we know that in this instance the girl in question refused to actually pursue her complaint --

A. Yes.

Q. -- and it really didn't go anywhere. Nonetheless the Board were reporting it to the Department. I suppose,

having had their knuckles rapped in 1983, they were not going to make that mistake again, even if this did not go anywhere. Would that be, do you think, a likely scenario?

A. Yes. I think --

Q. I ask the Board representatives a little bit more about this obviously --

A. Yes.

Q. -- but from a departmental point of view do you think the Department having said, "Look, you ought to be reporting these things to us", then the expectation on the Department's part would be such a matter would be reported from then on?

A. Yes. I think to be fair to the Board there would have been that heightened awareness on the part of all statutory and voluntary agencies by that stage that things had to be reported.

Q. The next matter is a matter that you yourself became aware of and you address that at 17.7. If we can just scroll on down, please. That's the LS66 matter from 1993, when you were a Social Services Inspector at that point in time, and a young woman, who had been a former resident of the Adolescent Unit that you had worked in, but whom you also had kept in contact with over the years, disclosed to you that she had been assaulted by

a male nurse, whom she named. You then provided a report on that to Dr McCoy, who was then the Chief Inspector, and to Mr Chambers, the SSI Assistant chief Inspector. You remember speaking to them at a meeting about the matter, and also the Assistant Secretary of the Childcare Policy, Mr Kearney, was at that meeting.

A. Yes.

Q. You then contacted police, and you understand that a senior official within the DHSS Management Executive contacted the Board. If we can just scroll on down, please. The member of staff was then put on a precautionary suspension and the police investigation ensued. The Inquiry has seen the police documents and ultimately no prosecution was directed and he was reinstated.

Now you at that stage did not know about the previous two complaints -- isn't that right --

A. That's right.

Q. -- from 1983 or 1986? We know then that shortly after that you then receive another piece of information about another girl, who is LS68, and that was when a social -- yes, a social worker, BAR8, who was employed at Barnardo's, contacted you to say that a patient -- a former patient of Lissue alleged that she had been sexually assaulted by a male member of staff.

You then wrote to Barnardo's seeking assurance that the allegations were being pursued with Social Services and that the matter would be brought to the attention of the police officer who was investigating the matter that you had reported to him. We know that the ACI wrote to DHSS Management Executive to advise him of the situation and Barnardo's confirmed that the relevant Health & Social Services Trust was pursuing the allegation, liaising with the police in relation to the previous allegation.

Then we know that the South-Eastern Trust wrote to the RUC and her -- at that stage her complaint couldn't be pursued because of a reluctance, largely on the part of her parents, to have any involvement in the matter.

You then wrote to Mr Veitch. You refer to pursuing the matter with the police, because you -- sorry -- if we can just scroll on down a little bit -- one of the concerns for the Department was, "Look, we need to be sure this is not a wider issue here". This is, as you felt, the second complaint about staff abusing children in Lissue and you wanted it made sure -- you were trying to ensure that the dots were being joined, as it were --

A. Yes.

Q. -- and that any implications for the children who had been resident there were properly investigated.

A. Yes. I think -- I have been looking at that documentation and I think my concern was that, although I had been made aware of the complaint in 1994, it was only when I corresponded with the Trust that I became aware that there had been an original complaint by this young girl made in 1990. I didn't know about that. I was aware then in 1994 she had then not wished to speak to police and -- the police, and there's some issue I can see about my view that there was an unusual time lag between the reporting of the allegations and the police interview, which the police explained by the fact that she wasn't willing to speak to them, but I was concerned that the police may have had information in their 1990 files that might have shed more light on the situation and it might have tied up with the report that -- with the complaint that I had reported in '93.

Q. In paragraph 17.14 you refer to being made aware of another complaint made in 2001. Police actually contacted you then about the previous allegations in '83 and '94.

Then you go on to discuss how in May 2008, following the allegations made by LS69, we know that led to what has been termed as the Stinson report or the Stinson review, which was a paper review of thirty-four central files.

Now we know from evidence that we have heard that none of the staff who were involved in Lissue or involved in those case notes that were looked at in the Stinson review were ever spoken to about the content of those.

I was asking you whether or not that was considered to be a satisfactory approach to the matter. I think perhaps you have an explanation as to why a paper review was considered appropriate.

A. Well, I think we have got to understand that we weren't dealing with significant -- a significant raft of complaints from former patients in Lissue. We had three to our knowledge at that stage, none of which appeared to relate to the same member of staff. The review that the Department asked the Board to undertake was in the context of the Department's concerns about other allegations that had been made in respect of another hospital, Muckamore Abbey Hospital, and, in fact, as a result of those there was a paper review. and the Department requested all Boards and Trusts to undertake a review of -- a sample review of files of in-patients who had been resident in all learning disability and mental health hospitals, not just children, but including children and vulnerable adults.

Q. Yes. I think you were saying that staff weren't spoken

to because where the review showed concerns about the practice or showed perhaps abuse --

A. Yes.

Q. -- currently being carried on in those facilities, then that was then referred to police --

A. Exactly.

Q. -- which led to a full investigation. So it wasn't considered appropriate to speak to staff in advance of any police investigation. Is that correct?

A. Of police investigation. Yes, yes.

Q. You do make the point that whenever the matter was investigated one member of staff was referred to --

A. The regulatory body. That's right.

Q. -- the regulatory body and also put on the register for --

A. Protection of --

Q. Yes, barring them from working with children and vulnerable adults.

A. Yes, yes, yes.

Q. What we have seen is that there's been a suggestion that in all of those reviews the approach taken was inconsistent across the board, as it were, and therefore the Department seemed to require further assurance about the rigour of the exercise, and that led to the set-up of the Strategic Management Group, the key findings of

which are set out at page 805 at paragraph 22.11 to 16.

But can I just -- yes. If we maybe just look at that quickly and then I will come back to something I wanted to ask. The key findings, as I say, are set out here:

"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.

There was inconsistency across Trusts on sample sizes, time frames and recording and analysis of findings.

It was difficult for the SMG to determine whether actions take at the time were in accordance with extant standards, as all policies and guidance weren't available.

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

The police had identified a number of challenges, including decriminalisation of some offences since that time, absence of identifiers, including names of alleged victims or perpetrators in the records, the fact that a number of the incidents were statute barred", such as common assault, "and the destruction of some patient records.

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

Now whenever this whole -- we know that Stinson was the first review and then there was a subsequent review of Stinson, if you like, by Mr Jacobs --

A. Yes.

Q. -- from the Maudsley. There was also a review by Moira Devlin looking at the nursing aspect of it.

A. Nursing.

Q. It is clear from a document that the Inquiry has seen that the Department was written to in March 2011 about the retrospective sampling. If we can look, please, at 11921. It is dated 9th March 2011. It says:

"Please find attached a report into the review of sample of cases of children who were admitted to Lissue and Forster Green Hospitals. You are aware from previous communications that the Health & Social Care Board has liaised with the Belfast Trust and PSNI in these matters and PSNI has confirmed that no further action will be taken in relation to the investigations (sic) they have investigated."

Now if we can just scroll down to the next page of that letter, please, you will see there about the recommendations that there have been as a result. Then:

"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 commonplace would not be tolerated today. It is also important to recognise that current in-patient 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."

Now am I right in thinking that this is the letter that effectively the Board is signing off on the Strategic Management Group work?

A. Yes, I think that's right, yes.

Q. So the report that is attached to that -- now it's been suggested that that might have been a report from October 2010, which is at --

CHAIRMAN: Before we leave that can we look at the next page?

MS SMITH: Yes. Sorry.

CHAIRMAN: I don't think we have seen that.

MS SMITH: Yes. Sorry. It just goes on to say --

CHAIRMAN: Yes.

MS SMITH: -- that the Health & Social Care Board were made aware of the findings of the exercise at a confidential board meeting held on 25th November 2010. Yes. Sorry.

Then there is an interim report from October 2010, which is at 1221, which appears to have been sent to the Department. Sorry. No. 12211. Sorry. I left off a 1. That's an interim report to the Department. If we can just scroll on down through this, please, it outlines the independent reports that were obtained that I was referring to and says that the allegations have been considered and passed to police. Then it goes on to set out of the staffing issues identified, and the next steps and that is:

"The Board considers that it is now in a position to make recommendations to the Department. They will be considered at the meeting in November 2010."

We then have a report from Ms McAndrew, which is at 13714, which was provided to the Inquiry late last Friday. In the body of this report for the first time we see the Board accepting certain things. If we can just scroll down through it, please, it sets out the background. Sorry.

CHAIRMAN: Do we have a date for the creation of that document anywhere, Ms Smith?
MS SMITH: We don't, Chairman.
CHAIRMAN: It is not given in the document itself.
MS SMITH: It is not in the document itself. It is unclear, but I think that this is actually the report that was referred to in the letter that we were just looking at of Ms McAndrew of 9th March 2011.
CHAIRMAN: Yes. That's the impression one would get, but I think the procedure, Dr Harrison, would be the report would be generated inside the Health & Social Care Board, then submitted to the Board itself for its consideration and ultimate approval --
A. Yes.
Q. -- and then it would be sent to the Department presumably under cover of the letter we just looked at of March 2011?
A. Yes. That's correct.
MS SMITH: It strikes me that this is actually the report that is being referred to in that letter. So if we just scroll on down, it just talks about the background and then the incident report, the methodology of the review, the independent review reports, and then on page 13716 it says there just at the paragraph -- just stop there, please:

"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 due attention to the conduct of a named member of staff, which is addressed later in this report."

It seems that in this report that the Board is submitting to the Department they are effectively accepting the results of the review and they are saying that it did show a harsh and punitive regime. Would that be your reading of that?

A. Yes.

Q. And that's what they are saying to the Department, "We accept that there was" --

A. Right.

Q. -- "a harsh and punitive" --

A. Exactly.

Q. -- "regime in Lissue", and Forster Green as well by implication.

Now was -- I mean, I know when we were talking, you yourself took issue with the view expressed by the Board about the multi-disciplinary working, saying that your

view was that there was evidence of multi-disciplinary working, and it was wrong for the Board to say there was little multi-disciplinary working.

A. Certainly my experience of working with Lissue and former patients there was that there was very much a multi-disciplinary ethos.

Q. We will ask the Board's representative maybe why they came to that conclusion.

A. Uh-huh.

Q. But certainly the Department then, when they received this report, they accepted the views of the Board?

A. Yes. Well, we certainly didn't challenge those findings, but were obviously very concerned about them and with Lissue in particular having closed, but with other institutions still being up and running the Department established -- its concern was such that we established the Strategic Management Group to advise on the way forward and assure us that things were very different today.

I should also say that I had actually forgotten when we were speaking earlier, but as far as I recall the Department also commissioned the Regulation, Quality and Improvement Authority to do a comprehensive review of learning disability and mental health hospitals and the report of that review also made several recommendations.

Q. I think it is true to say that the landscape that is being described by those who come to speak to the Inquiry in particular about what they experienced in Lissue, that the whole childcare landscape, as we know, has moved on from 1995, which is the end of our terms of reference --

A. Very much so.

Q. -- not just in terms of children's homes but also in terms of how children are looked after in hospital facilities.

A. Yes, that's right and, of course, we now have a very comprehensive social and clinical care governance framework, which was introduced in the early '90s and which is in place.

Q. I mean, I am not going to go into those, but coming back then, if I may, to your own statement, we were looking -- oh, yes. I just wondered the number of allegations -- as you have indicated, the Department did not challenge the findings of the Board that there was this harsh regime in Lissue.

There are a number of matters when we were talking that were identified where there was a question -- where questionable practices really were being used in Lissue. Sorry. I can't quite recall my own note of our conversation, Dr Harrison, but -- maybe I will just move

on to another point and then it will probably come back to me.

One of the things we were talking about when we were speaking earlier was that although there was legislation -- the legislation that governed the operation of Lissue was different to that governing children's homes, there was nonetheless a similar power to inspect in the sense that, as you have actually described to me, it was a much wider power under the health legislation to inspect not just hospital facilities, but pharmacies and GPs' surgeries. So there was a very wide power there for the Ministry --

A. Yes.

Q. -- and then the Department to go in and inspect if they had concerns.

Now you refer to it in paragraph 7 of your statement and say there was no evidence that that power was, in fact, used until 2005. To your knowledge was any consideration given to an inspection of Lissue when these matters were coming to light in the mid-1980s/early '90s?

A. To my knowledge I don't know. It's possible that some consideration was given about the need for action, but that I imagine had the three incidents been put together, that that would have been -- there would have

been some determination that there was a need for action on the part of the Board perhaps to investigate, but if we could go back to the power in the '72 Order, I think we wanted to make the point that this was a general power. It was not specific to hospitals. It referred to any arrangements made under the provisions of the '72 Order for persons. So it was as wide as that and I think we looked on it as a stop-gap power, and it is -- it is interesting to note that, for example, in the previous Act, the '48 Act, there was a power to inspect hospitals, but that didn't appear in the '72 Order.

I think the reason for that was that hospitals were deemed to be -- certainly as far as children were concerned, they were run by highly trained professionals. The children were not often in for long periods. Parents were visiting day and daily. In the case of Lissue children were going home at weekends. Therefore, there were safeguards in place that perhaps didn't exist within other institutions, and I think that was the reason that the Department perhaps hasn't -- didn't feel it necessary to go in and inspect at the time, and also there were monitoring systems in place by the Boards and the Boards reported regularly to the Department on complaints and any -- any untoward incidents and so on. There would have been regular

reporting.

Q. I think you were saying that essentially because this was a facility being run by professionally trained people, that really there was no reason to suspect that it was being run otherwise than on appropriate lines?

A. Yes, and consistent with accepted practice, particularly in mental health at the time, paediatric mental health. Uh-huh.

Q. And the trained professionals, they would have been subject to regulation by their own professional bodies --

A. Their own regulatory bodies, yes.

Q. -- which was different to the position which came to light in Hughes, where there was an issue about training and the monitoring of the practices of the people who were working in children's homes.

A. Absolutely.

Q. Paragraph 1 of your supplementary statement you talk about the Northern Ireland Health Advisory Service being sent up in October 1984 and its purpose being to help maintain and improve patient care in long-stay hospitals, among other things. If we can look, please, at 1407. Just there at 1.5, if we can scroll down, please just, you mention that the Department does not presently have access to information indicating whether

the NIHAS visited and reported on Lissue.
A departmental search of PRONI revealed that there ought to have been 150 files from that particular body, but only three seem not to have been destroyed.
I wondered had the Department yet checked those three files? I know you say and I think it is highly likely that they may not disclose anything because of the nature of the three files that still exist --
A. Uh-huh.
Q. -- but has the Department managed to check those ones?
A. We will certainly do this. I mean, I must apologise for not including this information about the Hospitals Advisory Service in the first statement, but, in fact, I really only discovered its existence by chance when I was trying to look at the antecedents of the Social Care -- of the Quality Care Commission in -- Care Quality Commission in England and discovered that a Hospitals Advisory Service had been established there, and it was only through an internet search that I discovered a similar body had been here. I am afraid our corporate memory at the moment in the Department only goes back as far as the 1990s, and I had to contact Dr McKenna, the former Chief Medical Officer, to actually check that the body was actually established in '84 and was up and running. So -- and I just discovered

this information last week. So we are happy to call those files in from PRONI and look at them and see if there's any relevant information, but, as I say, I'm very doubtful.

Q. Unfortunately, although there may have been Board inspections or even departmental visits to Lissue, we have no records of those in existence currently. Isn't that right?

A. That's right.

Q. The only report of any inspection or visit is that of the Mental Health Commission from 1987?

A. That's it.

Q. Is it possible -- I mean, I think we were having this discussion as well about inspections and what inspections could be expected to ascertain, and I think you describe it as a blunt instrument in saying if an inspection is being carried out, it is unlikely that abusive practices might come to light. Really they come to light as a result of complaints being made.

A. Well, complaints or those who are being abused learning to trust the people whom they are in contact with. If you take Lissue as an example, if, for example, the Hospital Advisory Service had visited there, that would have been perhaps a one-day visit by professionals, who would have been unknown to the patients, but those

patients were part -- they were seeing nursing staff, doctors, social workers. There was a very good social work team attached to Lissue. They were also in frequent contact with parents. They were only in Lissue, some of them, for very short periods. So one would expect those -- those channels of communication to be used, and certainly concerned parents would have had access to the complaints procedure. It's highly unlikely that inspections -- unless -- unless practice had been observed or information had been communicated to inspectors to that effect, it's highly unlikely that inspection would pick up problems such as those described.

Q. Just in respect of this, you were spoken to by someone who had built up a relationship of trust with you as someone who had worked with her formerly. I am talking about the girl LS66.

A. Yes.

Q. And obviously it was many years before she mentioned that to you?

A. Absolutely, yes.

Q. Certainly in some documentation, and I don't have the page reference, but it was the view that these complaints were seen as having a degree of credibility, even though they didn't result in any prosecution and

obviously were causing concern that led then to more investigations being carried out.

A. Yes. Uh-huh.

Q. In terms of -- we know -- and I will deal with this to some extent with the next witness -- but there were a team of social workers in Lissue. Might you have expected that those were people who would have built up a relationship with children so that they could have disclosed if anything untoward was happening at the time?

A. I would have expected so in the same way that community-based social workers should have that relationship with children, but we have got to remember that abuse is something that is not easily or readily disclosed by victims, and it can be many years before they feel confident for all sorts of reasons, and I will not go into those now, but it can be many years before they feel confident to come forward and tell even family, close family about what has happened to them.

Q. Equally another side of that is that given the training that social workers would have had, I think you said to me that you would have expected them to have picked up on poor practices in Lissue.

A. Certainly if they observed poor practice, yes, I would have expected them to have brought that to attention.

Q. Thank you, doctor. There is nothing more I want to ask you about, but I am fairly sure the Panel may have some questions for you, unless there is anything else that you feel you want to say about either of your two statements?

A. I don't think so.

Q. Thank you.

Questions from THE PANEL

MS DOHERTY: Thanks. Can I just ask: the issue about multi-disciplinary approach, could you give some examples of that? You say you did experience that in Lissue.

A. Yes. Well, I'm speaking from -- I think my memory is -- I remember I had a couple of children who were placed in Lissue, and I think Dr McAuley was the consultant and LS80, LS80, the social workers, and I remember being -- there being significant communication between us in terms of how to manage the behaviour of certain children. We also -- I didn't actually work in Tara Lodge, but I had management responsibility for that Adolescent Unit, and we had a couple of patients who were referred to us from Lissue, and again the -- you know, the communication that we had with the consultant psychiatrists and social work team and psychologists, where necessary, was extremely good. We had -- and, you

know, their input to reviews and so on was extreme... -- was very valued.

Q. I mean, one of the issues -- and again this is just from your experience -- one of the issues that has arisen is whether the children that were put into Lissue were children whose behaviour was such it was very hard for them to be placed anywhere else or for them to be contained within a children's homes as opposed to them having a psychiatric illness --

A. Yes.

Q. -- as we would know it. Do you have a view about that?

A. Yes, I saw that in the reports and there was some discussion that it was -- that some of the children were there due to a lack of appropriate facilities within the community.

Now again that wasn't necessarily my experience, but my experience, of course, is very limited to a few children.

Q. Uh-huh.

A. In particular, the girl who reported the alleged abuse to me in '93 was really quite -- had really quite serious mental health needs. She was diagnosed schizophrenic and had -- you know, had several episodes of hospitalisation. So, you know, that was not the sort of problem that children's homes would have been able to

cope with.

Again my experience was that once the treatment was completed, then -- and where children needed to come back into a community home, that there was ongoing support from the unit to staff working with those children.

Again a couple of the other children whom I would have been aware of had very severe problems of clinical depression and that in my view Lissue was the proper place for them at the time.

Q. So it was -- in your experience it wasn't that if there was a child those behaviour was really impossible to contain, it wasn't that Lissue was seen as an option there; it was about children that had some form of ...?

A. In my experience. Now there were other children whom I know again came my way -- I am just thinking of some of them -- who had very severe behavioural disorders and, you know, there's always this fine line between what is the mental health need and what is the behavioural need? It is unlikely to change and so on, but that's where Lissue was actually particularly helpful in terms of, you know, its programme -- its suggested programmes for behaviour modification and so on.

Q. Just a final question. I mean, the issue about what

inspection might have brought forward, if there had been an inspection of files and of the notes that you would have expected, then it could have been issues about restraint or behaviour management could have come to the fore if there had been an inspection?

A. Yes, I would accept that, yes, if children's files had been examined, and I know that that was the case in the 2005 inspection that I was involved in. I was actually involved in doing an inspection in Forster Green and we were concerned about the use, for example, of time out for children and made comments about that, but that came as a result of reviewing patient notes, yes.

Q. So that might have been a possibility. Okay. Thank you.

MR LANE: Just to follow up on the question about alternative places, obviously with the older adolescents they often moved on to training schools if there was difficult behaviour which needed to be managed and so on, but where would you consider children could have gone who were younger other than Lissue?

A. Well, again just off the top of my head and recalling from memory, it wasn't really until the 1990s that -- I'm trying to think -- the Department developed a residential child care strategy, and it really identified the need for differentiated accommodation in

children's homes --

Q. Yes.

A. -- and the need for units that dealt in particular with children who had challenging behavioural needs and, for example, needs of children who had been sexually abused, and so really our thinking wasn't that far advanced during the period that Lissue would have been working.

Q. Yes.

A. The differentiated accommodation amounted to, you know, long-stay, short-stay units, assessment units, but it wasn't until I think the Department produced its "Children Matter" strategy, which was informed by Board and Trust representatives and voluntary homes' representatives, that, you know, there was a strategy in place and units were established to deal with those types of problems.

Q. So that children's homes would have had to cope really?

A. Generally speaking, yes.

Q. Going back to the question of the interdisciplinary question, you gave evidence of how you thought there was good interdisciplinary working.

A. That's right, yes.

Q. If so, why do you think the review thought it wasn't happening?

A. Yes. Well, again I wasn't part of the review. So they

obviously had access to information that I didn't have. I didn't work within the unit itself. That would have been my experience as an outsider to whom children would have been referred.

Q. The other question that's linked with that: you didn't feel that the judgment about it being a harsh regime should be challenged?

A. I think the Department accepted on the basis of the evidence --

Q. Right?

A. -- that it was, and even some of the practice for the day at times appeared to have been very harsh and punitive.

Q. Okay. Thank you very much.

CHAIRMAN: Dr Harrison, if I can just follow up that last question about multi-disciplinary working, your experience with what you have correctly identified as a limited number of children who were there indicated that there was very good multi-disciplinary practices and an ethos to that effect. I suppose the question is well, if you experienced that, no doubt others would have done so as well; in other words, it wasn't just specific to your children, something that was laid on for them. I think it is fair to say that, and I can't put my hand on it now, I think there was criticism of at

least one of these reviews that they didn't speak to the staff, and you have explained why in one instance that was not thought proper.

A. Uh-huh.

Q. And, of course, it may be that a sampling of files does not fully reveal working day-to-day practices that simply may never be written down.

A. Exactly, yes.

Q. But in relation to the harsh and punitive regime, that appears to have been a view which each of the different reviews, whatever criticisms one might make about their methodology and approach, appear to have come to --

A. Yes.

Q. -- no doubt based on what they read in each file that they sampled or some of the files.

A. Yes, yes.

Q. As you say, the Department did not challenge that finding.

A. That's right.

Q. Well, thank you very much. That is the last question we have for you today. Whether we will have the pleasure of seeing you again I am not so sure.

A. Thank you.

Q. You have indicated that the Department will look at the three files in PRONI that came from the --

A. Yes.
Q. -- Northern Ireland Hospital Advisory Service or appear to have some bearing on it, and no doubt we will receive a further statement from you in relation to that or anything else that occurs. Should that happen, then we may, of course, wish to recall you. I should perhaps give you warning that should that eventuality arise, we would hope to do that on or about 26th, 27th April.
A. That's fine.
Q. But unless that happens and until then perhaps thank you very much for coming again today, and, of course, we have had the benefit of your extremely detailed -- as always, extremely detailed report and annexes. Because we don't ask questions doesn't mean we are not --
A. Thank you.
Q. -- grateful for them. Thank you very much.
(Witness withdrew)
MS SMITH: Chairman, I see the next witness has arrived. I would like some time to speak to him before he gives evidence.
CHAIRMAN: Yes, of course. We will sit again when we're ready.
MS SMITH: Thank you.
(11.10 am)
(Short break)

(11.50 am)

WITNESS LS80 (called)

MS SMITH: Chairman, Panel Members, our next witness this morning is LS80, who is "LS80". LS80 wishes to take a religious oath and he also wishes to maintain his anonymity.

WITNESS LS80 (sworn)

CHAIRMAN: Thank you. Please sit down.

Questions from COUNSEL TO THE INQUIRY

MS SMITH: LS80's statement is at LIS679 to 682.

LS80, just to reassure you that although the statement when it comes up -- that's 679 -- although your name is given in full here, before it is put on to our website we will have it redacted, but your social work career is set out there in paragraph 1. You were a Senior Social Worker at Lissue between 1979 and 1989 and afterwards for a short period of time --

A. Yes.

Q. -- I think at Forster Green.

A. One year, yes.

Q. Now you explain -- sorry. When we were talking, I was asking you to explain how social workers fitted into the structure at Lissue --

A. Yes. Uh-huh.

Q. -- and, first of all, I was wondering how many social

workers there were.

A. Well, usually there were two, myself -- I was a Senior Social Worker -- and there was another social worker. I think it was a social work post, but normally there were two of us.

Q. I was wondering then how you worked. Did you work Monday to Friday? Did you work weekends or what was the position?

A. We worked Monday to Friday.

Q. And on day shift only?

A. Yes, yes.

Q. In terms of the distribution of work, I mean, we have heard that there were twenty children as in-patients in Lissue and some five day patients maybe.

A. Uh-huh. Uh-huh.

Q. Did you have anything to do with the day patients?

A. Yes. Uh-huh. We divided the work between us basically, 50:50, something like that.

Q. It wasn't a case, though, of -- your role was not involved with the children on a -- as a key worker basis, for example.

A. That's right.

Q. That would be something for the nursing staff.

A. Yes.

Q. And if I have understood the discussion we had and what

you say in your statement -- can I just assure you, first of all, that the Panel have read your entire statement.

A. Uh-huh. Yes.

Q. So I am not going to go through it paragraph by paragraph --

A. Okay.

Q. -- although in paragraph 2 you do describe the role that you had.

A. Yes.

Q. You say that your role involved focusing on work with the parent of the children or those who were caring for them in their residential homes or foster homes.

A. Uh-huh.

Q. And you were the main link between the ward and families or carers involved as part of the multi-disciplinary team that agreed on the assessment and treatment plans for each child.

A. Uh-huh.

Q. I was asking what kind of interaction you actually had with children in the unit.

A. Well, I go on to talk about that later on, but some of my role would have been to check on the home circumstances, to get a sense of what the family was like, to do home visits, and from that point of view to

work with the families and see -- get some sense of the family functioning and how the child related to their parents or related to their siblings. So there was a sense in which my role was more global than just working just with the parents or just with the child. It was trying to get a sense of the overall functioning of the family, and some of that was done in home visits. Some of it was done observing in the unit as well when parents came to visit.

Q. Just in terms of home visits would you have done that on your own or would you have been accompanied by anyone else from Lissue?

A. Most of the home visits in terms of just following up on, say, a child that had gone home at the weekend, I would have gone during the week then to do a bit of a debrief with the family or whoever was there about that experience, but not exclusively. Some home visits were conducted with other members of the multi-disciplinary team.

Q. In terms of fieldworkers --

A. Uh-huh.

Q. -- who had care of children in -- either in the community or in a residential -- they wouldn't have been a fieldworker if they were in a residential children's home -- but the social workers who would have had the

more direct involvement with the child, what was your role in respect of them?

A. Well, it was very much a liaison role certainly with the fieldworkers, and with the social workers who worked in residential centres it was more of a kind of helping role in terms of how could we help them implement some of the ways that the child had been managed in Lissue. Could they do that in their children's home or not? What flexibility did they have to undertake some of the things that we did and took for granted?

Q. As I have understood the discussion that we were having, your primary function was essentially to work with the families --

A. That's right.

Q. -- in either family therapy session --

A. Uh-huh.

Q. -- or just with the parents on their own to help them to learn -- to train the parents how to manage their children using the techniques --

A. Uh-huh.

Q. -- that Lissue developed essentially.

A. Uh-huh.

Q. Is that correct?

A. Yes, yes.

Q. You also were saying that except for the family therapy

sessions that children would have attended in Lissue, or if you were going on a home visit, when the child might have been at home I presume --

A. Uh-huh.

Q. -- your role was not to interact with the children as such. That was left to the nursing staff in Lissue to -- and the teachers to manage them --

A. Uh-huh.

Q. -- on a day-to-day basis.

A. Yes, yes, and also the -- I mean, there's registrars, senior registrars in the unit as well who would have had individual interviews or individual contact with the child or children who were in the unit. So my role was more not direct, face-to-face with the children, young people, although that did happen at times, but it wasn't particularly my role as such.

Q. I mean, for example, one of the things that I was asking you was whether you yourself ever attended the morning meetings that the children had between breakfast and going to school.

A. No, no. They were nursing-led.

Q. Paragraphs 5 and 6 of your statement you talk about helping to train parents in the techniques to manage the children.

A. Yes, yes.

Q. That involved also some families coming into Lissue --
A. Yes.
Q. -- and staying in an apartment --
A. Uh-huh.
Q. -- that was there for them.
A. That's right.
Q. Paragraph 8 of your statement -- and I know I am jumping a little bit --
A. Uh-huh.
Q. -- but you talk about complaints procedures that exist nowadays being much more rigorous than they would have been --
A. Yes. Uh-huh.
Q. -- in the time you were working there in 1979 --
A. Uh-huh. The '80s.
Q. -- to '80s. We have seen -- the Inquiry has seen --
A. Uh-huh.
Q. -- that there was a circular about patients being able to --
A. Uh-huh.
Q. -- complain dating from 1971 --
A. Yes.
Q. -- that was sent from the Department to the various Health & Social Services Boards or at that time it would have been the Northern Ireland Hospital Authority in

'71.

A. Uh-huh. Uh-huh.

Q. Were you told -- were you aware that there was a procedure for complaints or what's your recollection?

A. I don't recall.

Q. And was it -- were parents advised that, "Look, if you are not happy with what we are doing here, you have the right to complain" or ...?

A. It's very unlikely, unlike today when that's much more upfront.

Q. The question I was asking was if you yourself, first of all, ever received any complaints from any children in Lissue in the course of family therapy or in the course of --

A. No.

Q. -- a home visit where they said, "A member of staff did this to me"? Nothing like that?

A. No, no.

Q. You do have recollection of one complaint by a parent.

A. Yes.

Q. Isn't that so?

A. Yes.

Q. I think you were saying it's one of them that is actually in the Stinson review.

A. Yes. Uh-huh.

Q. It relates to the child who got a black eye while being restrained.
A. Yes, yes.
Q. Perhaps if you could tell us a little bit what you recall about that. How did you come to be involved, first of all? What occurred?
A. Well, basically the mother came to the unit. The child had been restrained -- was being very violent and hard to manage. She was restrained by a nurse. In the restraint then she was being violent. She got hit on the eye with his elbow or upper arm and so she got a black eye. The -- a day or two later the mother came to visit, as most parents did on certain days of the week, and she was very unhappy about this. I talked to her. I talked to the nurse. I read the notes where it was identified and basically tried to make some sense of it for myself and help her to make some sense of it as well. The nurse came into the meeting with the mother and myself and a senior nurse, who was overall responsible for both the upstairs Child Psychiatry Unit and the downstairs unit, and I can't recall whether the mother was completely satisfied or not, but I don't recall that there was any further action from her to take it further or make a serious issue of it.
Q. Just to be clear, the people that we are talking about,

LS21 was the nurse involved. Isn't that right?
A. Yes. Uh-huh.
Q. And the overall person in charge of nursing was LS8?
A. That's right. Uh-huh.
Q. I am using names, because it is easier --
A. Yes. Okay. That's fine.
Q. -- but those names won't be used outside.
You talk in your statement again in paragraph 9 I think it might have been about restraint. I mean, this was an example -- it wasn't 9. There is no 9. Somewhere in the statement you talk about restraint or maybe I have -- it was something I wanted to ask you.
A. It's in paragraph 8.
Q. Paragraph 8. Sorry. You say there was -- formal training should have been in place for staff. Can we take it from that you never received any formal training in restraint?
A. That's correct.
Q. What about other staff? Were you aware whether or not they received any formal training, the nursing staff, or did you know?
A. I don't know.
Q. But you -- despite the fact that you yourself weren't trained, you have told me --
A. Uh-huh.

Q. -- that you would show a parent --
A. Yes, yes.
Q. -- how to restrain a child.
A. Uh-huh.
Q. How did you know then?
A. From watching the nursing staff on the ward and how they managed children there.
Q. And what about time out? Were you aware of that as part of the treatment --
A. Yes, yes.
Q. -- in Lissue?
A. Uh-huh.
Q. Have you any comment to make about that?
A. No. I think part of the difficulty is that we had children in Lissue who were -- conduct disorders who had maybe come from home or from a children's home, very, very difficult to manage, and these methods were found to be helpful to some extent in trying to manage them. Time out is well-established as a behavioural technique even with quite young children, and it depends how it is done just how -- whether you see it as a very punitive thing, whether you see it as quite a reasonable thing to be doing.
Q. Just in terms of that, I mean, you were here earlier when I was asking Dr Hilary Harrison about the Board

accepted in the document that I pulled up --

A. Yes, yes.

Q. -- that there was a harsh and punitive regime in Lissue.

A. Uh-huh. Uh-huh.

Q. First of all, is that your recollection or what can you say about that?

A. I think, as I mentioned, Lissue was a Child Psychiatry Unit for children with a mixture of issues or problems, if you like, emotional problems, school problems, anorexia, and then you had children who had conduct problems, which is still within the world of child psychiatry. We were dealing with these sort of children who are very aggressive, very disruptive, very non-compliant, sometimes very sexually active, not very responsive to counselling. So they need some management that is able to help them begin to manage themselves, if possible, and to some extent that regime, that behavioural modification regime was used in Lissue generally. It was particularly applicable for children with conduct problems who maybe came to the attention more than others because of their behaviour, but by and large the ethos seemed to work well for other children of a more neurotic kind of problem or more emotional problems, and the people when I was working there in general thought this is a reasonable way to be

approaching the problems of child behaviour.
Q. I think when we were talking earlier you said that the experience of some of the children, particularly those with conduct problems --
A. Uh-huh.
Q. -- they may well have experienced it as punitive and harsh.
A. Yes, yes, because of the frequency of their behaviour and the extremes of their behaviour. I mean, these are children who are very bad tempered, easily upset, very aggressive with other children, very disruptive. I do recall on one occasion the children on the roof of the building throwing slates off at cars that were parked below. So you were dealing with a level of disruptive and difficult behaviour that was -- we certainly saw as extreme, but you maybe had two or three children with that who had a conduct disorder and you had sixteen or seventeen others who were much less like that, much more easy to manage and deal with. So the frequency of their behaviour was high and therefore the frequency of time out or restraint also then was high accordingly really.
Q. You made the point to me that the difficult children were actually the minority.
A. Yes, I think so. Uh-huh.

Q. You also made the point that -- you were here when the last witness was giving evidence and was talking about specialist units --

A. Yes.

Q. -- that on occasions some young people, it was recognised that Lissue really couldn't help them --

A. Uh-huh.

Q. -- that they needed more specialist help.

A. Yes.

Q. You as part of your role would have liaised with units in England --

A. Yes, yes.

Q. -- and recommended certain units in England --

A. Uh-huh. Yes.

Q. -- to parents or to the Social Services --

A. Uh-huh. Uh-huh.

Q. -- who were looking after the family.

A. Yes, yes. The rationale for that was Lissue was a Child Psychiatry Unit but it wasn't a long-term unit. So the notion was children would come in and stay and be helped and treated and their families helped as well, but we did not see ourselves as, "This child is going to live here for the next three years or four years". So we needed somewhere with enough skill and ability and flexibility to manage some of these young people and

fortunately there were places in England that we could encourage Social Services to try and apply to get them transferred.

Q. Can I ask a couple of other questions about the hierarchy and the issue of -- first of all, before I go on to that may I ask about record keeping?

A. Uh-huh.

Q. You kept your own notes and records?

A. Yes, yes, that's correct.

Q. The nurses kept their own notes and records --

A. Uh-huh.

Q. -- and the consultants kept theirs. You believe that there must at some stage have been a composite file.

A. Yes.

Q. You certainly were able to go and check the nursing records --

A. Yes.

Q. -- if there was something that you wanted to find out about --

A. Uh-huh. Uh-huh.

Q. -- how something had gone, for example, the day before.

A. Yes, yes. Uh-huh.

Q. So there was open access --

A. Yes.

Q. -- to members of the team --

A. Uh-huh.
Q. -- to all of the records that were being kept on the children?
A. Yes. Uh-huh.
Q. In terms of the multi-disciplinary team that we have heard operated in Lissue --
A. Uh-huh.
Q. -- first of all, can I ask about the consultants? How often would they have been in Lissue?
A. They held weekly ward rounds, as they called them, weekly meetings where they discussed all the patients that they had admitted and that were being treated in the unit.
Q. In those ward rounds -- these were meetings of the team --
A. Yes.
Q. -- did they see the children?
A. Probably not. They may have, but probably not, because in a sense they were delegating that work to us in the unit.
Q. In terms of the hierarchy, what was the hierarchy? You were the senior social worker, though you seem to suggest that even though the person -- the other social worker was maybe a grade lower than you --
A. Uh-huh.

Q. -- on the pay scale, as it were --
A. Yes, yes.
Q. -- you very much worked doing the same job.
A. Well, I think the -- on the multi-disciplinary side you had registrars or senior registrars on the medical side, psychologists, social workers and nurses and generally those four disciplines worked together. So there was no sense of well -- apart from the consultants, who we kind of saw as separate, because they weren't usually involved in the work with us in Lissue, there was very much that sense of teams or sort of mini-teams developed between those four professions, if you like. So we saw ourselves as developing our therapeutic skills and our abilities to kind of work in more complex cases with each other as time went on and weren't so worried about our kind of like -- where we were on the pecking order of psychologists are better than social workers or whatever.
Q. Uh-huh.
A. So family therapy work was very much like that. So you had doctors, psychologists, nurse, social worker involved in those sessions with the whole family working as a team of equals and making decisions as a team of equals, which then went back to the ward round to say, "Well, this is what we are doing", you know, and get

some sense of, "Yes, that's good. Keep doing that" or some other advice from the consultant.

Q. The Inquiry has seen a Horizon programme that was made in 199... -- 1981 -- sorry --

A. Uh-huh.

Q. -- when you would have been in Lissue.

A. Uh-huh.

Q. It involved Dr McAuley --

A. Uh-huh.

Q. -- and his work in respect of two different families --

A. Uh-huh.

Q. -- but part of that -- I know you don't recall it or you don't remember having seen it --

A. Uh-huh.

Q. -- but part of that was clear that there was a nurse --

A. Uh-huh.

Q. -- who was acting out as the child --

A. Uh-huh. Uh-huh.

Q. -- and Dr McAuley and someone else in the room was observing the mother's interaction with the child, as it were.

A. Yes, yes.

Q. The other person who then seemed to be in the background having an input, one could have expected that to be a social worker --

A. Yes, it could have been.
Q. -- or another staff member --
A. Or a psychologist.
Q. -- or psychologist, something like that?
A. Yes. Uh-huh.
Q. But that's the kind of family training that you would have been involved in. Is that correct?
A. Well, in the report I mention that parents were admitted to the unit and it was very much with the view of parent training, so trying to help them cope with their children, who were often, if not always, beyond their control in the home or possibly in school or in public. So it is very much you bring them in and you help them to manage. You teach them to manage their child by demonstration, by watching how nurses manage children on the ward. Could they learn how to do that? Could they learn how to use time out? Could they do it in a way that was safe? Could they do it in a way that was productive? Those kind of things.
Q. Just in terms of this multi-disciplinary team --
A. Uh-huh.
Q. -- you have heard the criticism that the Board made that there was little evidence of working in a multi-disciplinary way.
A. Uh-huh.

Q. I just wonder what your view of that is.
A. I just do not understand where that comes from, because the way -- as I have described to some extent, the way the whole thing worked was we did work as a team of professionals together under the auspices of the consultant and with their overall authority. So virtually -- okay. Nurses did manage the children on the ward. Teachers managed children in school and looked after that side of things, but in terms of therapeutic endeavours with the families or the children or both, that was all done as a team. So I don't know where that comes from. Very much the strength of what we did was because we were able to work with different professionals and have different perspectives on the work as well.
Q. Well, LS80, thank you. There is nothing else that I am going to ask --
A. Uh-huh.
Q. -- but I am sure the Panel Members may have some questions for you.
A. Okay. Thank you.

Questions from THE PANEL

CHAIRMAN: LS80, can I just ask you one question about the locations in England that you referred to where if a child needed long stay --

A. Uh-huh.
Q. -- admission to somewhere, then it was open to the staff at Lissue to try and pursue the possibility with Social Services --
A. Yes.
Q. -- that the child could be transferred? Do you remember that happening at all --
A. Yes.
Q. -- or frequently, or how often did it happen?
A. Well, it was infrequent, because they are very expensive. So you had to persuade Social Services or whoever was managing the budget that this would be an investment that's worth doing, that we no longer could really manage that young person.

There's at least one comes to mind, a young man, 14/15-year-old, who went I think to somewhere in Liverpool, which is some kind of a therapeutic community, and that worked very well. There were others, but I couldn't tell you how many. It was infrequent, but it was always a kind of option to be looked at and to be seen, "Well, can we -- can we get this?", because within Northern Ireland or I suppose Ireland itself there was limited options outside of a training school, and we didn't want children to go down that juvenile justice route, if we could avoid it.

Q. Yes. Thank you.
MS DOHERTY: Thanks, LS80. Can I just ask in relation to the meetings where it was agreed what the regime would be --
A. Yes.
Q. -- was it medically led? Was it the consultant who had the final say in relation to what approach would be taken?
A. Well, you had basically two consultants. One had one kind of theoretical approach, which was behaviour management. That was Roger McAuley.
Q. Uh-huh.
A. One was Billy Nelson, who was much more initially psychotherapy and then moved towards family therapy. So you have got those two kind of consultants with different, if you like, ways of looking at the problems. So in a way with Roger it was always going to be a behavioural approach. That was a given. Then it was a matter for us then to work out the detail of that in a team. So are we going to put some child on a points programme or ...? That kind of approach based on behaviour management techniques.
Q. And would there ever be a discussion -- like a child is coming in and there would be discussion to say, "Should this child be Dr McAuley's or Dr Nelson's?" on the basis

of the presenting problem as opposed to, you know --
A. I can't remember. I am not sure about that.
Q. So would it be a case --
A. Basically I suppose in out-patients -- they had their own out-patient clinics. So cases that they -- were referred to them where they thought, "Well, actually we can't work with this in out-patients. He has to got to go to in-patients at Lissue", then it would be their patient and then we would take it from there.

Now, having said that, clearly -- Dr Nelson will say this himself -- the regime in the unit was very behavioural --
Q. Okay.
A. -- you know. So that was a kind of given, that that's the way children would be managed generally.
Q. That's helpful, because that was going to be my next question in a way, that if you have got two different regimes --
A. Yes, yes.
Q. -- did that create problems for the children and how they were ...?
A. No, I don't think so. I think it was quite consistent, and I think also in the school you had a kind of similar sense of agreement that this was a good way to work. You are working with children very much. How can you

reward them? How can you encourage them? How can you motivate them? If they are very difficult, are there sanctions you can impose that could be appropriate in the school setting, and that sort of -- there was a good overlap between what the school were doing and what the nurses on the ward were doing --

Q. Uh-huh.

A. -- and the school attended the ward rounds and ...

Q. Would all families be involved in family therapy or would that --

A. No.

Q. So you would have Dr Nelson's --

A. Yes.

Q. -- children, the families would come in?

A. Yes.

Q. For Dr McAuley --

A. Uh-huh.

Q. -- that would be about looking at behavioural techniques --

A. Yes, yes.

Q. -- and encouraging the use of that.

A. Yes.

Q. Can I just ask, given that you had a role to help to look about the generalisation from the hospital to the family situation or the home --

A. Yes.
Q. -- for behavioural techniques --
A. Yes.
Q. -- how did you have the opportunity to observe then in the ward? Did you spend time ...?
A. Well, I suppose my office was just beside the ward. So I was in and out of -- on the ward every day, into the nursing office every day to see what had been happening, having chats with people in the nursing office. So the little kind of eating area was just opposite. You could see nurses managing children's behaviour daily --
Q. Uh-huh.
A. -- and also you get a good sense what's working for them? What's not working for them? So what could a parent do? Could a parent use some of those ideas or not?
Q. I mean, we have heard descriptions. Some people have said about, you know, children swinging from the chandeliers or that the mornings were particularly difficult in trying to get them settled. For you being, you know, there on the site did it feel as if behaviour and kind of eruptions of bad behaviour were a common ...?
A. There were some, but I don't recall anybody swinging from a chandelier.

Q. Probably they didn't have a chandelier to swing from!
A. When you have children who have a conduct disorder, you expect there to be problems. You expect that there will be non-compliance, there will be temper outbursts and aggression and that kind of thing. So that wasn't uncommon. It wasn't a daily occurrence --
Q. It wasn't a daily occurrence.
A. -- in my recollection anyway.
Q. Can I ask were you ever involved in restraint yourself?
A. Only if I was trying to help a parent learn how to do that. So part of my role and part of the role of all of us there, so me along with a nurse and maybe a psychologist, would be doing parent training, so parent admissions. So you were trying to say, "Well, look, if a child is completely uncontrollable, this is how you could hold the child in a way that's safe".
Q. But that would be about modelling as opposed to your hands being on a child?
A. No. I would have -- I would have demonstrated how to do it and the nurse likewise would demonstrate how to do it. I was never formally trained how to do it and in a sense that's one of the things that would come up, you know, because now, of course, the training around restraint and care and responsibility -- in fact, I did that as a trainer when I moved posts in 1994 --

Q. Uh-huh.
A. -- but in those days we basically watched other people do it and modelled our behaviour on that.
Q. Behaviour on that.
A. Yes.
Q. Was that -- did the consultants lead that or was that about nurses? I mean, when you arrived there, what you learnt about restraint, was that --
A. Uh-huh.
Q. -- from the nurses mainly?
A. Yes, yes.
Q. The incident with the child with the black eye --
A. Yes.
Q. -- were the doctors involved in that? Were they aware of the complaint?
A. They would have been aware of it, yes, yes, and there was a process -- an untoward report went up. I am not quite sure where it went to. Maybe in terms of line management it went to -- LS 95 would have been the line manager for the social workers at that time and then it became LS 96 , who were Assistant Principal Social Workers.
Q. I was just going to ask that, about your own supervision.
A. Uh-huh.

Q. So who would have supervised you?
A. That's a good question, because I think, going back to this idea of becoming a kind of team of practitioners, I think that the social work supervision was light compared to today and certainly compared to statutory Social Services, where I later went then in 1990 as a team leader, where supervision was every month and looked at files and you -- there was a greater degree of, if you like, just supervision really.
Q. Oversight.
A. Oversight, yes. Uh-huh.
Q. When you say light, how light?
A. I think it would be if an issue had come up that I needed some help with or I needed to discuss --
Q. You could approach somebody?
A. Approach them, yes.
Q. As opposed to kind of a monthly meeting --
A. Yes, yes.
Q. -- to consider your ...?
A. Yes. Uh-huh.
Q. So issues about work load, work balance, how you were working with families --
A. Yes.
Q. -- all of that was for you to deal with --
A. Uh-huh. Yes.

Q. -- unless you brought forward a ...?
A. Yes.
Q. Your support for your practice came off the multi-disciplinary team then from the ...?
A. Yes, yes, that's correct.
Q. Did you think that was satisfactory at the time?
A. Well, I think at the time I saw myself more as a senior practitioner. So that was -- to me that was consistent with that. Now there may be weaknesses in that, which I would admit, but that's how I saw my own role.
Q. Okay. Thanks very much.
A. Okay.
MR LANE: Just a follow-up on that one. Who are you actually accountable to?
A. I would have been accountable initially to the consultant --
Q. Uh-huh.
A. -- for the work done.
Q. As your line manager?
A. No, just because he had the -- for example, when I worked in out-patients, so out-patients clinic, you would have the same sort of set-up of a multi-disciplinary team of a consultant, psychologist, social worker -- no nurses obviously -- but all the work we did there, we were accountable to the consultant for

that work --

Q. Yes.

A. -- and really that pattern was repeated in Lissue. So ultimately they were the person with the responsibility and we were all accountable for our work to them.

Q. So the consultants were accountable for the individual cases --

A. Yes.

Q. -- in that respect, but who would have been your line manager then? Would it have been somebody in the hospital?

A. Yes, in out-patients. was the line manager.

Q. And he was --

A. She.

Q. -- she -- sorry -- a Principal Social Worker or something?

A. An Assistant Principal Social Worker I think.

Q. That's helpful. Did you have any specific training for this role by the way --

A. No.

Q. -- working in Lissue?

A. No.

Q. Right. In terms of staff meetings and so on, we have heard obviously about the morning meetings with the children --

A. Uh-huh.
Q. -- and we have heard about the ward rounds, but were there also meetings where all the staff came together to discuss --
A. Yes.
Q. -- the running of the unit? How often would they have been?
A. Well, there were meetings -- there were different meetings, but there was certainly a -- I think it was called the academic meeting on Tuesday afternoon.
Q. Uh-huh.
A. So myself and others from Lissue would have gone up to The Royal for those meetings, which were very much kind of general meetings about what was happening in the work in our setting. There would have been training experiences there as well, lectures given or videos and this sort of thing. So that would have been a place of kind of meeting to discuss things and also training as well --
Q. Right.
A. -- there.
Q. Were you at all involved in the use of the room where there was video --
A. Yes.
Q. -- cameras --

A. Yes.
Q. -- and there was the one-way window and so on?
A. Yes, yes, there was.
Q. Which side of the window would you have been? Were you an observer or participant?
A. Both, both. In both, because the family therapy approach was very much based on an idea of you have a family who are in the room. There is somebody there, one of the multi-disciplinary team, is in the room with them, one person, who has a kind of earphone --
Q. Uh-huh.
A. -- and then you've got the other three or four behind the screen watching what's going on and at times then saying, "Maybe you could ask them this", or "Ask them that", or "Don't go there", or "Don't go here". So that was kind of like that way of working.

Equally then when we were doing the parent training, sometimes you are in front maybe demonstrating and modelling good parenting and then sometimes you are behind the screen just watching and observing and giving some feedback as well that way.
Q. Did you play back the videos much for training purposes or to analyse the case?
A. Yes, we would with the family -- certainly with the parent training and trying to say, "Look, here's -- you

did that well. That's working well. Why don't you do more of that?" or "That's not working so well".

Q. Okay. Thank you very much.

A. Okay.

CHAIRMAN: Well, LS80, that's all we need to ask you. Thank you very much for coming to speak to us today.

A. Thank you.

(Witness withdrew)

MS SMITH: Chairman, there is another witness, but I think if we take lunch now, then we can probably start her ...

CHAIRMAN: I will say not before 1.30.

MS SMITH: Yes.

(12.30 pm)

(Lunch break)

(2.10 pm)

MS MARY HINDS (called)

MS SMITH: Good afternoon, Chairman, Panel Members. Our witness this afternoon is Mary Hinds. Mary wishes to take a religious oath, Chairman.

MS MARY HINDS (sworn)

CHAIRMAN: Thank you, Mary. Please sit down.

Questions from COUNSEL TO THE INQUIRY

MS SMITH: Now Mary is a co-signatory to a joint statement that has been provided by the Health & Social Care Board, which is at LIS079 to 479, and the other two

joint signatories are Fionnuala McAndrew from Health & Social Care Board and Dr Carolyn Harper from the Public Health Authority and yourself from the Public Health Authority.

There is also a further statement from Aiden Murray, who is the Assistant Director of Mental Health and Learning Disability in the Health & Social Care Board, and that's at 1073 to 1132, largely dealing with the Paediatric Unit, but there is also material in his statement to which we will refer.

You helpfully set out your career and qualification -- your career path and your qualifications on page LIS1405, Mary.

A. Uh-huh.

Q. It is true to say that you never, in fact, worked in Lissue. Isn't that correct?

A. That's correct.

Q. You are not, as you reminded me, a mental health nurse either.

A. That's correct.

Q. Your background was in Accident & Emergency?

A. That's right.

Q. There are a number of documents which you gathered together and which were sent to the Inquiry late yesterday afternoon, including a table about governance

and nursing codes of conduct.

A. Uh-huh.

Q. I am not going to call them up, but they can being found in the bundle at 13721 to 13728, although I think it might be more than seven pages. In fact, I know there are more than seven pages, because I looked at them, but I have written down the numbers incorrectly obviously.

Is there anything in particular in those documents that you wish to highlight or bring to the Inquiry's attention?

A. I produced a paper to help myself reflect on what's happened in the intervening years since Lissue was open, and I suppose the one to highlight to the Panel Members and the Inquiry is the developments around 1995 with the introduction of clinical and social care governance primarily as a result of the Paediatric Cardiac Surgery Inquiry in Bristol, also informed, you know, by previous inquiries, where we now have a system by which we gather together pieces of evidence and information which better inform how a service is actually being run, the quality of that service, and I think that's an important thing when this Inquiry is considering the future as well.

Q. Basically when we were talking about the whole issue of governance and so forth, the join -- the dots are now joined in a way that they weren't before. Isn't that

correct?

A. Absolutely right. It has been a consistent theme of both Bristol, Mid Staffs and numerous other inquiries that we fail sometimes in our health and social care system to join the dots which might lead you to know what a service actually is like at the front line.

Q. Well, if I can come to the statement that's on the screen and, first of all, ask you to confirm that this is the statement --

A. Yes.

Q. -- that was provided by both the Health & Social Care Board and the Public Health Authority. That was in direct response to a series of questions that the Inquiry set out in its Rule 9 request for a statement and it has been answered in the order in which those questions were asked.

A. Uh-huh.

Q. Just to confirm that the Inquiry has read the entire statement and not just the paragraphs that I am going to refer to.

A. Uh-huh.

Q. If we can go, first of all, to paragraph 13, which is at LIS081, and it is talking -- it is actually paragraph 13 and 14. You are talking about the number of people who have complained to the Inquiry against the number of

patients who would have been admitted to the -- I am going to deal primarily with the Psychiatric Unit of Lissue.

A. Uh-huh.

Q. You say that that ten applicants -- in fact, there were eight applicants referring to the Psychiatric Unit. So that represents less than 1% of the children admitted to the in-patient unit over its eighteen years of operation.

A. Uh-huh.

Q. Now obviously that is not taking account of the police complaints, the civil claims and those identified in the retrospective sampling exercise -- exercises I should say. So while the percentage might increase slightly if we add those into the mix --

A. Uh-huh.

Q. -- it's still a small fraction of the number of patients who were treated there.

A. Yes, I think that's right.

Q. Paragraph 17 of your statement, if we can just scroll down, you say here that:

"In 1981 the history of Lissue that's exhibited describes it as offering residential treatment or 24 hour intensive treatment of psychological disturbances manifest in children under the direction of

the consultant, Dr Nelson."

Then you talk about Dr McAuley joining the team, as it were. It says:

"The previously eclectic milieu changed to absorb a more behaviourist approach which incorporated intensive behaviour modification programmes. At the same time there was the beginning of family admissions focusing on the child management skills of the parent."

Now there seems to have been before then -- Dr McAuley comes on the scene there is just a broad spectrum of approaches being taken within Lissue up until 1976. He comes in and then there is this cognitive behaviour therapy --

A. Uh-huh.

Q. -- and the behaviour management techniques that he devises and uses. Dr Nelson then subsequently layers on top of that the family therapy, if I have understood correctly how it operated.

A. Uh-huh.

Q. So arguably -- we also heard -- those are differences of approaches --

A. Uh-huh.

Q. -- to the children in the institution. We also heard from the Nurse Ward Manager yesterday that he had set up children's meetings in the morning, so another layer of

--

A. Uh-huh.

Q. -- interaction with the children in the unit. It is clear from all of that there were a number of people having a say in what was happening to children in Lissue.

A. Uh-huh.

Q. Would that be correct?

A. I think that would be correct, yes.

Q. Paragraph 20 then you go on to discuss the fact that the in-patients who were in Lissue, given the children who were seen in the out-patients clinic, the children who were taken in as in-patients were likely to have been the most complex of patients being treated in The Royal Belfast Hospital for Sick Children.

We have heard also that there were children who were placed there by Social Services on an emergency basis, that while the primary route was through the Child Psychiatry Clinic --

A. Uh-huh.

Q. -- there were other ways into Lissue.

A. Yes, that's right.

Q. Can you comment on why that was, why it wasn't just confined to hospital admissions?

A. I think it would have been a response of the service to

a child in crisis or a child in need, and I think of the time they probably didn't have many alternatives than Lissue for admission of these particularly challenging and very sick children.

Q. You also say that there would have been limited access to the facilities in England.

A. Oh, absolutely. I mean, I think the previous witness commented about rare occasions when patients would have moved to England for very, very specialist services. Children do have to go to other units in the rest of the UK. That happens today, but it would have been even rarer in those days.

Q. We know that Lissue was governed initially by the Northern Ireland Health Authority and then the Eastern Health & Social Services Board. We know that the Mental Health Commission visited in 1987.

A. Uh-huh.

Q. First of all, just to confirm there are no documents that you have been able to find in existence about any inspections of the Paediatric Unit?

A. No.

Q. And in 1987 the Mental Health Commission identified an issue about adequacy of staffing.

A. Yes.

Q. Can I just pause and ask a little bit about that,

because we were talking about what would be the requisite number of nurses per patient bed. You have estimated I think it was just over one.

A. I think when -- on the information I've got available, and it was of its day, I have estimated that they probably had about 1.13 nurses per bed. In today's language that would be equivalent to a surgical ward, and I think you have to bear in mind this was a children's intensive care unit, not in the way we think of an intensive care unit in a hospital, but that's actually what it was. The modern equivalent is a staffing ratio of about 3.3 nurses per bed.

Q. So although in 1987 the Mental Health Commission wasn't actually looking at it in those terms --

A. Yes.

Q. -- they were correctly identifying that there was inadequate staff levels?

A. I think again based on the information I have their visit was in 1987, and if I recall documents, there was an indication that the occupancy rate was going up, and if they were also admitting more acutely ill or other admissions to the unit in an environment where there were multiple care models, that would be bound to have a stress on staff.

Q. Well, in paragraph 39 of your statement you believe that

Lissue would have been visited by the Belfast Hospital Management Committee and later that the Area Executive Team of the Eastern Health & Social Services Board was likely to have visited annually.

A. Uh-huh.

Q. We have no documents to show that there was inspection by either the Ministry of Health and Local Government or the DHSS in later years of Lissue. We heard Dr Harrison on that point earlier. The Health & Social Care Board and Public Health Authority view is that there would have been inspections carried out on Lissue at Board level.

A. Yes. Unfortunately we don't have any written evidence of that.

Q. Paragraph 54, if I can turn to that. I don't have a page reference. I think we will just have to scroll down, I am afraid. Yes. It's here. It is known that following its establishment in 1983, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting became the nursing profession's regulatory body. Among other things it had to monitor the quality of nursing and midwifery education courses.

A. Uh-huh.

Q. You are aware that in June '88 there was a memo -- and we can look at that in a moment -- from Miss Grant, who

was the Director of Nursing Services, to Mr Lyons, who was the Assistant Group Administrator, that the National Board inspection of January and February '87 withdrew approval as a nurse teaching unit as the philosophy of care was seen as restrictive and custodial, and that the structure and layout of Lissue was not seen as well suited for its present purposes. We can see that memo at LIS226, which is clearly a response from Miss Grant to Mr Lyons in light of a letter that was sent by the three consultants to Dr Greer, who was the Acting Chief Administrating Medical Officer -- Administrative Medical Officer, and that's dated June '88.

Now presumably the three consultants would have been Drs Nelson, McAuley and another consultant, probably Dr Manwell.

A. I would assume so, yes.

Q. I mean, this is around the time when the discussions of transfer from Lissue to Forster Green are ongoing.

A. Yes.

Q. We will see that there are various things in the memo that really are talking about the feasibility of the provision -- the facilities I should say in Forster Green.

A. Uh-huh.

Q. If we just scroll on down, there is the reference which

you make -- there is an interesting comment here about:

"A large number, up to twenty, of children of varying ages, temperaments and background, plus perhaps some parents do not integrate well as a herd and become difficult to control."

Well, we know that's exactly what was happening --

A. Uh-huh.

Q. -- in Lissue, first of all, and then it goes on a little bit about the plans. Then there is the entry that you were referring to.

A. Uh-huh.

Q. "The National Board of Inspection of January/February '87 withdrew approval as a nurse teaching unit as the philosophy of care was seen as restrictive and custodial and the structure and layout of Lissue was not well suited for its present use."

Now we don't have that report. Isn't that correct?

A. That's correct.

Q. But Aiden Murray in his statement makes reference at paragraph 8 to this at -- that's at page 1090. Sorry. Paragraph 8 is 1074, first of all. What he says is:

"The Board is aware through minutes of the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland that an inspection of Lissue Hospital was undertaken by that Board in January 1987. A copy of

the inspection report is not available to the Board, but the minute of meetings note that concerns were raised as a result of same. The inspection is also referenced at paragraph 54 of [your] statement. The minutes now available indicate that in 1987 the National Board accepted recommendations of their Education Committee and Mental Health Nursing Committee that neither the psychiatric ward nor the paediatric ward in Lissue would be approved for nurse training purposes. On 8th April '87 the Education Committee also considered that their grave concerns should be drawn to the attention of the Area Board of the Eastern Health & Social Services Board. The meeting of 9th December records receipt of a letter from the Chief Administrator of the Eastern Health & Social Services Board. Members noted that many of the items raised had been dealt with and extracts from the National Board's minutes that reference Lissue throughout '87 are at exhibit 2."

That's -- I was talking about the next page is at 1090 and this is -- if we can scroll down, please, you will see there in paragraph 6.3.1.1 the Colleges of Nursing are reporting on an inspection of the clinical facilities, Child Psychiatric Unit of Lissue Hospital, and:

"Having examined the report, it was agreed to

recommend to the National Board that the Child Psychiatry Unit at Lissue Hospital be not approved for nurse training purposes."

If we can go on to say that:

"It was also agreed to recommend that further consideration of the unit for approval would require the under-listed conditions to be met and be subject to a satisfactory re-inspection.

1. Policies and procedures for the nursing management of the children should be reviewed and in this context particular attention should be given to:

1.1. The need for a philosophy on which to base nursing care.

1.2. The need for the current pattern of excessive door locking.

1.3. The supervision of children who abscond from the unit."

Then there's storage of medicines, videotapes.

"Copies of the appropriate nursing training programme should be available in the unit",

which suggests they weren't.

"Learning objectives and teaching/learning processes designed to facilitate their achievement should be developed.

An adequate clinical teaching service."

From the Inquiry's viewpoint rather than the clinical teaching aspect --

A. Uh-huh.

Q. -- of these minutes it is clear that this is the basis on which -- I have forgotten the name -- Miss Grant --

A. Uh-huh.

Q. -- formed the view that the philosophy was in some way custodial because of the locking of the doors.

A. It is all I can assume from these minutes, because unfortunately we don't have the complete report, although we do continue to look for it. I think if it was anything more, if it was about individual nursing practice that they seen that they felt was inappropriate or harmful, I think the National Board would have made note of it, given they have made note of other issues of concern in their minute, but that's my assumption. Because I don't have the full report, I can't be sure.

Q. But certainly there must have been something in the inspection --

A. Uh-huh.

Q. -- about the locking of doors that caused them a degree of concern.

A. Yes. I mean, it's noted there. I think what is also interesting is the Mental Health Commission went into Lissue the same month and the same year and their

reference, as I recall it, is that doors were lockable but they didn't make any comment about excessive locking of doors. I think we know from the information we have now that dormitories would have been locked, kitchens would have been locked, you know, and there would have been a range of areas that would have been locked.

Q. And they would have been locked to keep children out --

A. Out.

Q. -- rather than to keep them in?

A. Yes.

Q. There's a later minute at 1130 which indicates that:

"The contents of the Education Committee in respect of the response of the Training Committee of the College of Nurses to the above report was referred to and receipt was noted of a letter dated 7th October '87 from the Chief Administrator" -- if we can scroll down, please, to 4.11 -- "representing the response of the Eastern Health & Social Services Board to the report. Members noted that many of the items raised had been dealt with."

A. Uh-huh.

Q. So it's uncertain whether or not they were dealt with satisfactorily --

A. Satisfactorily.

Q. -- to an extent where approval was given for student

nurses to return to Lissue, but we know that this was coming to the end of Lissue's time before transfer to Forster Green in any event.

A. I think that's right, yes.

Q. One of the other things that came to the attention of the Inquiry is there were children as old as 16 being admitted to Lissue when it was never designed to have children of that age group.

A. Uh-huh.

Q. Again can you make any comment as to why that might have happened?

A. My only conclusion could be that there was nowhere else for these children to go. At that stage -- actually right up until today the admission of a child into an Adult Psychiatric Unit is abhorrent and high risk and I think it reflects some of the statements that have been made before about appropriateness of admission. I think they probably had nowhere else to go.

Q. Yes. Again I think it was the Jacobs report --

A. Yes.

Q. -- that suggested that there were children being placed in Lissue because a social worker couldn't deal with them in the community --

A. Uh-huh.

Q. -- and that that was inappropriate for a Psychiatric

Unit.
A. Yes.
Q. Again is it the case there really was nowhere else?
A. Yes.
Q. Perhaps in the circumstances -- I mean one person who has spoken to the Inquiry and whose records we will look at in due course was admitted on an emergency basis because of his behaviour in a children's home. It wasn't -- it is interesting. I mean, from the documents relevant to him it is clear that the nursing staff were -- I mean, his behaviour was such that he -- he's been spoken about in terms of having thrown slates off roof on to -- roofs on to cars and so forth --
A. Yes.
Q. -- and it is clear that the nursing staff were complaining, "He is not supposed to be here".
A. Yes. I think you are right, and I think one of the sisters actually wrote to express their concerns about that particular admission.
Q. Paragraph 59, if we can go back to your statement -- I will just find the page reference; it is at page 093 -- you talk about:
"From 1973 the nursing staff came under the control of the Lisburn District under the Health & Social Services Board -- Eastern Health & Social Services

Board" -- sorry -- "who took on administrative responsibility for the hospital after reorganisation. Clinical links were maintained, however, with the parent hospital, which, following reorganisation, fell within the North Belfast District."

Now I am going to look at that a little bit, if I may, because I was showing you --

A. Uh-huh.

Q. -- the history of the Royal Belfast Hospital for Sick Children that was written for its anniversary, I think ninety years' anniversary or something. It is exhibited to Dr Harrison's witness statement. I can get the reference in a moment.

It is clear that there was this split between the Lisburn District and the North & West Belfast District.

A. Uh-huh.

Q. The medical staff still came under the authority, if you like, of North & West Belfast. Nursing staff were then looked after in Lissue.

Now the Department -- if we look at the extract from that book, and it is 815 to 817, if we can scroll down to the bottom of that page, please, it goes on here:

"Undoubtedly the event which caused most concern and dismay to the staff was the transfer in '73 of administrative control of Lissue from North & West

Belfast District to Lisburn District. In May of that year The Ministry of Health, soon to become The Department of Health & Social Services, issued a memorandum to members of the Eastern Health & Social Services Board and the Area Executive Team's Central Services Agency concerning the overlap of services."

If we can scroll on down, essentially it says that:

"In the appendix cases of overlap between districts in an area were set forth with Lissue being quoted as an example.

Lissue had 58 beds.

The Hospital Management Committee, Belfast Association, annexe of Belfast Hospital for Sick Children.

Catchment area is predominantly greater Belfast. Comparatively few patients are normally resident in the Lisburn Health & Social Services District."

Then it goes on to:

"The Ministry's position was stated in a letter from the Chief Medical Officer to the Chairman of the Medical Staff Committee and it says:

'We have given considerable thought to this question of overlap between districts within an area and have recently issued a circular to the Area Boards giving guidance on this subject. Basically we feel that in

general Area Boards should be responsible administratively for all facilities within their area, but we do recognise that there are special cases, such as Lissue hospital, where for very specific reasons the administration should continue to be the responsibility of a district other than the one in which the facility exists. We have asked Boards to look at the overlap problems and to keep us informed of their decisions. To me it seems that Lissue presents one of these exceptional cases, and I feel it would be very easy for the Eastern Health & Social Services Board to resolve it in this way.'"

It says -- it goes on to read:

"The Board did not agree and ignored this nudge from Dundonald House. Lissue was hived off to the Lisburn District."

Then it goes on about staff concerns about that and the dispute rumbling on. If we can scroll on down just, it says:

"With hindsight, the decision to remove administrative control of Lissue from the North & West Belfast District while leaving responsibility for patient care in the hands of the medical staff of The Children's Hospital looks very much like a triumph of bureaucracy over common sense."

It goes on to say:

"Lissue staff were content with the way Lisburn District handled their day-to-day services."

I wanted to explore that a little bit, if I may, with you. First of all, why do you think the Board ignored the advice of the Department or their nudge?

A. I can only assume they got caught up in local population needs in terms of it was physically located in a population. Therefore the population -- the organisation that served that population should look after that service. I think as a consequence you had a multiplicity of accountability lines, communication lines, information lines and therefore no -- and I can understand the frustrations expressed in this history, because you had no one organisation looking out for Lissue and all the services that Lissue provided. I am sure everybody did their best to work together, but hospitals are communities of practitioners. Of course they are made up of doctors and nurses and clerical staff and all the pieces and the elements that go together, but actually one of the best ways of describing a hospital is a community of practitioners who work together in the best interests of the patients that they serve. I think the managerial and organisational arrangements that Lissue through this

period had to work with didn't help them make that happen.

It is interesting, because it appears an exception was made for Muckamore Abbey, which is based in Antrim, but managed through the Belfast Trust still currently.

Q. I think the comment that you made to me was that the structures don't lend themselves to the strength of having a total picture of the unit.

A. Yes.

Q. That total picture could be missed because there was no-one with overall control, as it were.

A. It is the in charge question. When you walk into a building, if you ask someone, "Can I speak to who is in charge?", if you walked into Lissue, they would have said, "Of what?"

Q. Going back to your statement, Mary, paragraph 67 you make reference to there being an incident book in Lissue. That has never been located. Isn't that correct?

A. No.

Q. Paragraphs 70 to 73, which is on 095, you talk about the issue of restraint.

A. Uh-huh.

Q. And you conclude -- I am not going to go through all of the statements, but you conclude that:

"Restraint was used in circumstances necessary to safeguard the child or others from risk of harm."

A. Uh-huh.

Q. I am wondering whether that is a fair conclusion to reach, because we have heard that there was an inconsistent approach to restraint. I am just wondering what more you wanted to tell us about restraint.

A. I believe the nurses involved -- the nurses would have been the people who would have done restraint, because they are the ones that would have been closest to the patient 24 hours a day, and they are the people who would have enacted behaviour modification programmes and others. The evidence we have in terms of Stinson and the extracts from the patients' notes indicate that restraint was noted and recorded in the nursing notes, which gives you reassurance that it was an open and transparent process. The problem we have is we haven't got the context of the total, so we haven't. Many of these children were very disturbed and many of them required -- and you have heard from staff in Lissue -- required particular management and therefore intervention, and I think mental health services always have this challenge between care and control, and it's a very skilled practitioner that can do it with

compassion and kindness. I think we have heard evidence -- the Inquiry has heard evidence that some staff took a perhaps more gentle approach, but it would have been on a spectrum, so it would, and I believe that the restraint used was to safeguard the children.

Q. You did say to me when we were talking earlier that really it would all depend -- you know, you could have all the training in the world in a technique, but it would really come down to the individual applying that technique and the individual patient.

A. You are absolutely right. You can have all the policies in the world and all the protocols in the world. It is the practical application of that in the work place that is key, which goes to, you know, the ethos, the value base that is nursing and indeed social care.

Q. I just wondered in the context of different approaches taken --

A. Uh-huh.

Q. -- by staff was there any suitability at the time Lissue was operating of staff suitability for the roles that they were being asked to undertake? I know there was the qualification, the Mental -- sorry -- the Registered Mental Health -- Mental --

A. RMN, Registered Mental Health nursing, yes.

Q. Yes -- that they would have had if they wished to apply

for the job after a certain period of time.

A. Yes.

Q. But I am just wondering about their suitability of the role of working with children.

A. At that stage no. I mean, the normal process, you know, because this was around the '70s, '80s and into the '90s, and I started nursing in 1978 as a student, and the standard at that stage was references and good character references. It has moved on since then in terms of having other checks done on staff before they join the profession.

Q. Another issue is individual treatment plans.

A. Uh-huh.

Q. We have heard that those were devised. That was the ethos --

A. Uh-huh.

Q. -- of Lissue. Might those have led some children to believe that they were being treated more favourably?

A. Yes. I think -- I mean, again I am not an expert in the field, but if you just look at it very logically, we had different models of care. Each child had a different treatment plan, which might have meant that their sanctions and rewards were different than another child's sanctions and rewards, and they lived in close proximity to each other, and they can talk and they can

walk and they can engage, and they I am sure would have compared notes, which -- absolutely I can see how some children would feel treated differently than other children.

Q. And that in turn then could lead some children to feel resentful and maybe play up and act out more?

A. Potentially, yes.

Q. One of the points that you made about that is that there were no -- this was an environment -- the physical environment of Lissue was not suited for a situation where you had children having multiple types of treatment.

A. Absolutely. I mean, basically it was an old manor house bequeathed by the Lindsay family for the care of children around the War and was never purposely designed for the care of those particular children.

Q. I am going to move on to an incident you talk about at paragraph 82 of your statement. That's about the -- I have forgotten the actual designation of the child; I will just use the first name -- David, and what came to light in March 1983 in respect of him.

There is a report of the Deputy Administrative Nursing Order (sic) referred to but was not, in fact, attached to the statement and was only provided to the Inquiry late yesterday afternoon. Now that was

unfortunate and I am putting it on the record that it was unfortunate, because the witness who I took yesterday afternoon had some angst, and it is recorded, for example, in this document we are going to look at shortly that doors had glass panels in them.

A. Uh-huh.

Q. If we look that, it is LIS1416.

A. And maybe could I apologise for the late arrival of this paper.

Q. I know that it was an administrative oversight --

A. I apologise.

Q. -- but it has been unfortunate, because this is an interesting contemporaneous document of what Lissue was like in 1973.

A. Uh-huh.

Q. It is recorded here that:

"On 3rd May the Chief Administrative Nursing Officer informed", this is the Deputy Administrative Nursing Officer, "that an allegation of sexual assault had been made by a former patient of the Child Psychiatry Unit. The allegation was made by a boy who had been an in-patient from August '82 to September '82. He stated that he had been sexually assaulted by another patient on three occasions during this time. The assault was alleged to have taken place in his room at

night."

Then it records the nursing investigation and importantly it records:

"To enable me to undertake the investigation with speed and thoroughness, I recalled the Nursing Officer, LS 8 , from annual leave."

Now when we were talking earlier, that was quite an exceptional step to take.

A. Quite an exceptional step to take. It also reflects nursing of its day, because if you are called to come in, you come in, even if you are on your annual leave.

Q. Also the point that I would make about that is that him coming back from his annual leave is going to set, you know, the alarms bells ringing by staff. People want to know, "What are you doing here? What's happening? What's going on?" So it would be impossible for those working in the unit not to be aware that there is some investigation going on.

A. That would seem sensible, yes.

Q. It then goes on to describe the geography of the unit. It says:

"It is a 20-bedded unit, with five day places.

The physical layout of the building is such that the day rooms, dining room, day toilets and even outside play areas are all on one level within the same area,

making day time supervision of the children relatively easy. A separate pool room, tennis court and playing fields are some distance from the main building and the children use these under staff supervision, mainly in the evenings, at weekends and during school holidays.

Night accommodation (known as 'the bothy') ...",

which is something that was puzzling me certainly when I was looking and seeing that term in some of the documentation:

"... is on two levels. The first, consisting of three four-bedded rooms, is on the first level opening off the dining room, the second on the upper level consisting of eight single rooms reached by stairs from the first level at the opposite end from the dining room.

One of the single rooms has an observation glass screen between it and the nurses' duty station to permit increased observation of a child where this is indicated.

Each level has a nurses' duty station and patient toilet/shower accommodation.

All bedrooms have glass panels in doors and all rooms have dimmer fittings on lights so that children can be observed without being disturbed.

There is an internal telephone link between the two

duty situations and between each of these and the rest of the hospital.

There is also a buzzer in the nurses' duty station in the upper level of the bothy, which is wired to the dining room area, and can be used to call staff if extra help is needed."

Then it goes on to say:

"Children admitted to the unit are allocated beds according to their sex and bed availability. Where possible older children would be allocated the single rooms to recognise their increasing need for privacy and independence, but this would be influenced by the reason for their admission and the medical programme of treatment prescribed for them.

In the main the bothy sleeping accommodation is locked during the day and children are only there if physically ill or as part of their treatment programme. Children wishing to read, etc, in their rooms in the evenings must have permission to go there and all are closely supervised.

School age children go to school during normal school hours (unless their treatment programme requires otherwise), the younger children remaining in the unit.

A large proportion of the children go home for the weekend, leaving on Friday evening and returning on

Sunday afternoon."

There are appendices referred to in this which we don't have.

A. Uh-huh.

Q. "Bedtime in the unit starts around 7.00 for the younger children, unless there's a special treat allowed, such as an outing or TV programme. All the children would be in their bedrooms by 10.30. One the bedtime routine begins, the sleeping area is staffed and is not left unattended throughout the night.

The sleep patterns of children are monitored and recorded on a nightly basis. Each sleep pattern record becomes part of a child's in-patient records and is considered with other aspects in assessing a child's progress and response to treatment."

It then goes on to discuss the age group of the children and says that they are up to the age of 14.

"Evidence, however, in more recent times that a considerable number of children have been over 14 years and one at least 15."

Then the nurse staffing -- total staffing reflect -- the time equivalence is 22.73, reflecting the need to provide for:

24-hour cover.

The admission at any time of a seriously disturbed

child.

The possibility of a child having to be returned.

Treatment programmes.

Family therapy.

And at that same time recognition is given to the fact that many of the children spend part of the day at school and many go home for the weekend."

Then the recruitment policy is discussed.

"They are recruited to either day or night duty on a full-time or part-time basis, but all staff understand the need for flexibility and may be rostered if necessary.

The need for continuity of care is recognised.

The staff consists of Nursing Sisters, Charge Nurses, Staff Nurses, SENs and Nursing Assistants.

Both male and female staff are recruited so that children may live in a setting resembling that of a family and society in general as far as possible.

Staff on taking up a post follow a planned orientation programme."

I think we heard from LS81 about that.

"Nursing assistants, who do not require prior training or experience, complete an in-service training programme."

The staff qualifications and experience are set out.

I am not going to go through them, but they are quite clearly -- all fifteen of the nurses are trained. Then it goes on to say:

"There is no recognised training in child psychiatry for nurses, but every effort is made to ensure that staff attend study days, seminars and conferences as available in the psychiatric field.

There are weekly multi-disciplinary clinical meetings run by the Child Psychiatry Division at the Royal Belfast Hospital for Sick Children which the nursing staff attend regularly.

There is a small library available for staff and monthly nursing journals in the psychiatric and general fields are provided.

The turnover of staff is small. Sickness and absentee rates are within the upper third of the district. Two incidents of long-term illness."

If we can just scroll on down:

Staff relationships and morale.

Close working relationship between the disciplines, which includes the school staff on site. These are mature and stable working relationships.

No evidence of fiction among nursing staff. Considerable pride in the unit and the improvements they have helped to bring about in the physical condition of

the building and the development of play areas.

Staff morale has been good, but the allegation under investigation is undoubtedly affecting it at the moment",

which again suggests that the staff knew what this was all about.

A. Uh-huh.

Q. Duty rotas then:

"Two full-time Charge Nurses on day, one Nursing Sister full-time on night duty, although she is also responsible for the Paediatric Unit.

Overlap of staff, where one day staff member is rostered until 10.00 pm Sunday to Thursday, which ensures there is sufficient staff available to supervise bedtime activities."

It goes on. Nursing students are not included in the rosters, but we know that certainly up until 1987 student nurses were there on a four or six-week rotation.

A. Uh-huh.

Q. Would there have just been one nurse sent or ...?

A. It depends on what the National Board would have approved. They would have set the level depending on how many registered nurses, what the learning environment was, and for a unit that size it could have

been up -- anything from two to four, so it could.

Q. Nursing policies. There are clear written policies on which grades of staff to be rostered, rules to be observed if change of duty becomes necessary, overtime and the ratio of male staff that may be rostered.

There are also two night security officers appointed with a minimum of one on duty each night.

Then communications:

"The approach to treatment in the unit is very much a multi-disciplinary one and there are regular meetings between all the professionals regarding the programme for and progress of each child.

Nursing communication is well established with written reports on all children on a twice-daily basis or more often, if this is indicated. There is a formal verbal handover between staff at the end of each duty period, supplemented by written instructions and observations as necessary.

There is also a regular Heads of Department meeting when the professionals meet to discuss the work and development of the unit as a whole.

The lines of communication within nursing are known and used. The Nursing Officer meets the Sisters/Charge Nurses on a regular basis and they in turn keep their staff informed on the day-to-day matters concerning the

unit.

There are good communications between night and day staff" -- sorry -- "day and night staff with Night Sister being fully involved in meetings, recruitment of staff and development of nursing policies."

Then the summary is:

"I have examined all these matters in detail and had discussions with the Nursing Officers, Nursing Sister and Charge Nurses. I believe the policies are sound and there is adequate provision for the nursing care of all children brought into the unit. I have one reservation -- the more recent tendency to admit children over 14 years is of some concern to the nursing staff in the unit. These children have increasingly different needs from the younger children and in some instances have patterns of behaviour which, because of their physical size as much as anything else, cause fear in the younger age groups.

These older children often require a fairly different approach to care and treatment as they hover between childhood and adolescence, and it can be difficult to pursue the diverse range of care and treatment which this group needs as well as manage the care of the younger children.

While fully appreciating the needs of this group and

the absence of a unit for adolescent psychiatry in the province, this pattern of admission could produce strain and stress if pursued.

There has been some discussion between medical and nursing staff on this subject and I have now asked the Nursing Officer to seek further discussion with the consultants so that the whole matter of the admission of the upper age group and its related problems may be examined."

We know that this then led to the upper age limit of 13 --

A. Uh-huh.

Q. -- being imposed:

"Turning again to the allegation, it must be accepted that if this allegation is true, then our policies and systems did not protect this child. There are four possibilities:

1. The philosophy of the unit permits a degree of freedom and encourages independence and the development of a good self image in the child. This means an element of risk which must be accepted.

2. The policies and practices in the unit were adequate but there was a failure in performance by the staff at post at the time of the incident."

Now we know there were three incidents complained of

by this boy.

A. Uh-huh.

Q. "3. An element of each could exist.

4. The more recent tendency to admit over 14-year-old children is stretching the unit beyond that with which it can be expected to scope."

She said:

"A. In completing this investigation I have sought to ensure that nursing staff fully understand their role and responsibilities.

B. Since the police inquiries are not yet complete, I have not taken any action to counsel staff on this particular incident."

Now you explained to me, Mary, that counselling staff is actually code for disciplining staff.

A. Yes. It is a term that quite often would have been used in nursing prior to any disciplinary action being taken.

Q. If the District Administrative Nursing Officer is recording that they have not taken any action yet --

A. Uh-huh.

Q. -- because of the police inquiries ongoing to discipline staff, the suggestion is that staff --

A. The inference is --

Q. -- ought to have been disciplined?

A. The inference is she is planning to do something.

Q. Yes. If I can move on to talk about a couple of other things. Paragraph 105 of your statement you talk about the Stinson report. Now -- or Stinson review. Mr Stinson has been credited or perhaps discredited with this review. He was one person of a team of people who worked on this review. I think it is important it was a review led by the Eastern Board.

A. Uh-huh.

Q. It would appear certainly that no member of staff was ever consulted or asked about the files that were being examined and we heard Dr Harrison this morning --

A. Uh-huh.

Q. -- say that it wouldn't really have been appropriate to have asked them --

A. Uh-huh.

Q. -- if the review was going to lead to maybe a police investigation, that that wouldn't have been the course taken.

A. Uh-huh.

Q. It was all done on the paper.

I think you also want to make the point that the cases -- that the extracts that are in the Stinson report are simply that. They are excerpts from summaries of files.

A. Yes. My understanding is Stinson reviewed extracts that

had been prepared or drawn out of patient files. I think the challenge with that, while I understand the desire to get to the nub of any issues, because I think there was a genuine desire on behalf of the legacy Eastern Board to protect children, I think as a consequence you didn't get the whole picture of the care of each individual child, so you didn't.

Q. And so, therefore, there may have been an over-emphasis on notes that might have caused concern without looking at what notes were on either side?

A. Potentially, yes, and I think that's where you miss the multi-disciplinary nature of care, because the focus is on one particular area and not on the total care of each individual child.

Q. I'm going to go back to your statement. At paragraph 132 onwards, which is at LIS117, the question is posed by the Inquiry:

"What systems failures, if any, relating the HIA Inquiry's terms of reference can you identify from the material?"

Without going through all of these, if we go to paragraph 140, it is recorded there that the allegations made by former patients of Lissue were considered at the time of those allegations being made certainly to be credible.

A. Uh-huh.
Q. The boy LS 71, the interim report written by Marion Reynolds in respect of the girl that we heard about from Dr Harrison this morning, but she felt certainly on the balance of probability it is, however, likely that her complaint had a basis.
A. Uh-huh.
Q. We know that ultimately the police investigation led to no prosecution in that case.

I was just wondering what was -- what was the view -- why do you think that it was seen as -- these complaints were being seen as credible at the time?
A. I think based on the information I have they were considered credible on the basis of the experience particularly of the individuals who -- you know, professionals who were engaged in reviewing these. You know, Marion Reynolds in particular was a highly respected senior social worker with a significant background and I think the Eastern Board had to listen to her and should have listened to her, which is why I think they considered the allegations to be considered credible.
Q. If we can scroll on down, please, to 141, you talk about the withdrawal in that paragraph of the -- of Lissue from the list of national teaching units --

A. Uh-huh.

Q. -- nurse teaching units. I beg your pardon. That would be in keeping with the conclusions of the Board and its predecessor, following the historic case review process, that there was a harsh regime in Lissue.

I am just going to come to that. Again this comes from a document which was only provided to the Inquiry last Friday evening, which is the report of Fionnuala McAndrew. It is in the bundle at 13714 to 13720. Her letter enclosing a report to the Department is at LIS11921 and we looked at that earlier --

A. Uh-huh.

Q. -- today. We looked at both of these earlier today. Perhaps if we just -- worthwhile having a look at them again, because I know you want to talk to us about that.

First of all, the letter is at -- the page reference is 11922, which is the letter of 9th March 2011, and in the second page, if we can scroll down, she makes reference that:

"However, it is ..."

Sorry. Just scroll up, please. In that final paragraph:

"In making their recommendations, all three reports highlight the need to consider the findings in the context of practice at the time."

But goes on to say:

"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."

She goes on to say that:

"Specific individual issues about staff members have been appropriately addressed."

A. Uh-huh.

Q. The actual report at 13715, which I think it is clear from my looking at it this was the report that was included --

A. Uh-huh.

Q. -- with that letter, talks at page 13716 about:

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

Now this was something that was the view of the Health & Social Services -- Health & Social Care Board taking into account what it had seen in the Stinson review, the Jacobs report and the report of Moira Devlin.

A. Uh-huh.

Q. I know that -- I have been told certainly that this was

the last act of the Eastern Health & Social Services Board was to accept Stinson and those reports, and the Health & Social Care Board inherited, but Fionnuala McAndrew or Marion Reynolds certainly overlapped between the two.

A. Uh-huh.

Q. I know that you wanted to say something more to the Inquiry about this apparent acceptance of those reports as disclosing a harsh and punitive regime.

A. Yes. As you say, the Stinson report and the other reports were the last handover from the legacy Eastern Board into the new Health & Social Care Board, and I think the emphasis at that time of all of the work of the Board was to ensure that whatever systems and processes we had in place continued to protect children. So I do not think -- and I was there -- we did not do a reflection on whether the process of the Stinson inquiry -- report and indeed others was fulsome and complete in its work. The focus was ensuring that children were safe.

I think since then and as part of this Inquiry in terms of us looking again at how Stinson was commissioned by the previous Eastern Health & Social Care Board, the fact that extracts alone were used, the fact that Stinson didn't get the opportunity to see the

total package, the total care of the child, the fact that staff on duty weren't interviewed, while I understand the emphasis and indeed the previous witness, the context probably has got lost somewhere along the way in these inquiries -- these reports.

If you were to ask me about harsh regime and that term "harsh regime" which comes up, I think I have tried to listen to the applicants who describe it as a harsh regime and we have to hear them. I have listened to the staff, who don't recognise it in the way that the applicants do. I think if you don't understand behaviour modification as a philosophy and as a model of care and you see children getting sanctions as well as rewards and you see one child in one therapeutic regime and another, I could absolutely see how it can become a harsh regime. If you are a nurse in mental health, you will see the care in a different way than I would. If I were to go into Lissue and watch the care, I probably would think it's harsh as an A&E nurse and as a mother. I think if I was to take one of the nurses from Lissue and put them in a busy A&E Department on a Friday night, they would probably think that's a bit harsh and a bit chaotic where that is my bread and butter. So there's something about the context and the eyes that we looked upon -- through in terms of these

particular care regime in Lissue.

I also think we have a parent, and I know -- I think it was in the television programme, who described it as brutal, but that it had results. So I think we have now, on reflection, a number of different perspectives. I think, given today's standards, there were elements of it that were still harsh. I am not an expert in behaviour modification, and I think you will hear that from the experts tomorrow, who will describe why it had to be the way it was, but I think the context got lost a little bit along the way.

Q. And so on reflection, and in the statement the Board said that it intended to reflect on the evidence --

A. Uh-huh.

Q. -- and while we haven't yet come to the end of the evidence --

A. Uh-huh.

Q. -- am I right in understanding that the position of the Board now is that they don't necessarily accept that it was a harsh regime?

A. I don't think we would accept that it is as black and white as that, because I think the context has got lost. I think if we look at the inspection processes we have now with RQA, a different approach is taken, and I think it is important to reflect on that. RQA will do the

paper sift of policies and procedures, because that's important, and those are the systems that help control how things happen. They will then go and spend time in the unit, not just one day or two days. They will spend time, a week or more often. They will also seek out the views of young people and parents. So, for instance, I know VOYPIC, which is the Voice of Children and Young People, is used by RQA -- it's not -- the Mental Health Commission -- and this is no criticism -- would have written to the Chief Executive and said, "We are available should any parents and children want us". So it was quite a passive engagement with children and their parents. Now it is much, much more active. RQA will also talk to staff. In other words, they will get a much more rounded picture of what a service is actually like.

Q. Mary, thank you. You will be glad to know that I have nothing further that I want to tease out of your statement, but I am sure the Panel Members may have some questions for you.

A. Okay. Thank you.

Questions from THE PANEL

CHAIRMAN: Does it come down to this, that in relation to the last matter you've been discussing that the Board's view is that the earlier investigations were perhaps

inadequate and led to unsustainable conclusions?
A. The previous reports were not complete. I wouldn't --
Q. Well, perhaps you would just answer my question.
A. Sorry. Would you repeat that again?
Q. Is it the Board's position in essence that the investigations which led to the conclusion at the time -- a number of conclusions by different people that there were harsh -- a harsh and punitive regime were based on an inadequate investigation and led to an unsustainable conclusion or may have done?
A. Yes, they may have done, and to be fair to Mr Stinson, he did what he was asked to do.
Q. Of course, another way of looking at it is that the type of regime which operated may on occasions have lent itself to being harsher and more punitive than was justified.
A. The type of regime you mean by way of multiple models of care and behaviour modification?
Q. No, the way people were treated. I am not talking about the therapeutic aims of the treatment. That's outwith our remit.
A. Uh-huh.
Q. But the way people were actually handled may on occasions have gone beyond what was appropriate.
A. I think you've had --

Q. That's another way of looking at it.
A. Yes, it is another way of looking at it, and I think you have had a member of staff here describe that there was a spectrum of approach within the one policy, restraint.
Q. Yes. Thank you.
MS DOHERTY: Thank you. Can I just follow that up, Mary?
A. Uh-huh.
Q. I hear what you're saying about Stinson --
A. Uh-huh.
Q. -- but you have got the National Board doing an inspection visit for two days, presumably with the competence to know what level of practice they would want in a mental -- and they actually say it was custodial.
A. I think that's a very interesting point, which is why I have pursued that in trying to find the report, which I failed to do and I will continue to do.

On reflection, if you look at the minutes -- and your colleague here read out those particular areas -- I think the term "custodial" is in relation to the use of locked rooms or locked doors. I don't know that for sure, because I haven't got the complete report. If I thought -- if the National Board seen practices that were inappropriate by way, for example, of restraint, I think they would have made mention of those. If they

were going to mention a philosophy of nursing, if they were going to mention locked doors, if they were going to mention -- earlier on in the minutes they mention a boiler being broken. If they were going to mention those things, I have to ask myself the question: "Would they not have mentioned poor practical clinical practice?" I don't know.

Q. No. I mean, I suppose what I feel about minutes is that minutes are for the public consumption by their very nature, for the NMC, the UKCC at that time. So there would be an issue of what they might put in their minutes and, you know, their inspection reports. It seems to me that if it was just about locked doors, you could equally take it the other way round.

A. Absolutely.

Q. It's a huge -- it's a huge decision to remove approval for nursing to be provided.

A. You are absolutely right. I only know of one other place where that happened and indeed it was at the request of the Ward Sister, because she was under too much pressure and she felt she couldn't provide a good educational environment for students. So you are absolutely right. Without the full report it is very difficult, but we will continue to pursue to try and find the full report, because we only found

those minutes quite recently, so we did, and one of my staff is doing that, trying to find them.

Q. I wondered whether NMC may have the archives of the UKCC.

A. Unfortunately we have tried that too. The National Board minutes and records are supposed to be in PRONI, but it has taken us -- one of my staff this time to get those minutes, because it all depends on what they have catalogued them under, and you really do need to know the business to be able to chase down the record. We will continue to look for that report, because, like you, I believe that is absolutely crucial --

Q. Uh-huh?

A. -- to giving those of us that were not part of Lissue a better picture of Lissue.

Q. That's really helpful. I agree with you. Can I ask: did Forster Green get the approval returned?

A. No. Well, they have had -- they weren't approved for student nurse training in those minutes and I don't have a record of them getting student nurse training returned. Neither do I have a record that Lissue got student nurse training returned. So I don't know.

Q. We don't know if they sought it but didn't get it or didn't do it.

A. We don't know. At this stage I don't know.

Q. Could we look into that as well --
A. Certainly.
Q. -- because again if it is an issue about locking doors or boilers being broken, those are matters easily dealt with in a new ...
A. Well, that's absolutely right. Actually on the movement to Forster Green those hopefully would have been sorted, because it would have been a more purpose-built environment.
Q. I mean, one of the things that I was quite surprised to hear was about staff not receiving training in restraint, including the person you heard this morning discussing that, and in a sense being not only was it that they were retraining children, but then they were providing modelling and training for parents in how to restrain children, including in their own homes. That kind of learning by watching other people seemed -- do you have a view?
A. No, I would agree with you. I am not overly surprised that social workers in that environment didn't receive training, because they wouldn't have been the 24 hours a day hands on staff. I trained in 1978 and it was an acute hospital and I got restraint training. So I would be very surprised if they haven't. They may well not have kept very good records and indeed the

National Board -- if you remember from the note that was read out to the Inquiry, there was reference to the lack of training records, but I would be very surprised in that particular environment if there wasn't training on restraint. I have no records to prove one way or the other.

Q. We can only hear what we have heard about.

A. That's absolutely right.

Q. Which links to the issue about where the child -- the issue of peer abuse. We heard from the senior nurse yesterday --

A. Uh-huh.

Q. -- who said that he wasn't -- I mean, we are accepting it is a long time ago that we are talking about --

A. Yes.

Q. -- he wasn't aware of the incident and does not remember any training around that time into dealing with sexual behaviour amongst children.

A. Again -- based on the DANO's report on that particular incident, the fact that the nursing officer was called back in, the fact there was reference to "and there could be poor morale hereafter", I would be surprised -- it's small unit as well, and in small units, you know, communication is probably slicker than sometimes you would want it to be. So I would be surprised if

everybody didn't know or a significant proportion didn't know, but that's my assumption. I have no evidence one way or the other.

The amount of training that would happen for nursing staff in very specialist areas probably would have been pretty limited in those days. There certainly would have been child protection training, but I think it was later on in the '90s with safeguarding for children that actually everybody got included, because quite often it was seen the preserve of the health visitor or indeed people who worked in very specialist areas, such as indeed Lissue, but I think the training would probably have focused on a more general nature, and indeed in some of the minutes in the National Board that I have read there is actually reference to the National Board themselves saying they didn't feel they had somebody appropriately trained to train the nurses in Lissue in this very specialist area, and there's a note that they were going -- they were considering sending somebody to England to a specialist unit to get them up to speed to enable them to train.

Q. But even if you take away the kind of notion of external, you know, cutting edge practice training --

A. Yes. Uh-huh.

Q. -- the notion that the staff weren't brought together to

say, "Okay", you know -- I mean, this issue about the counselling --

A. Code.

Q. -- to counsel, do we have any records to show whether that then did happen, whether any counselling happened or any disciplinary?

A. No. I mean, we know there were regular staff meetings, but I don't think there are any records. We know they were training, because there is reference to they would get two half day training or two days' training. I can't remember where it is, but it is somewhere in all of the papers, but no.

Q. No specific disciplinary action on the back of this?

A. Not that I am aware of. I don't have that information, but, as I say, we will continue to try to find the report. I think if we find the report for the National Board, that will give us a perspective of what the total picture of Lissue was like.

Q. Just the last question you will be glad to hear is that in a sense what we heard today from the social work perspective was that it was a multi-disciplinary team really managed by the consultants and their view.

A. Yes.

Q. In relation to -- and just from whatever you know about this -- were the nurses acting independently as well or

was there -- I know that the Matron of The Royal had a position and would come to visit sometimes --

A. Yes.

Q. -- but was there a sense that Lissue even in terms of the nursing profession was seen as something that was on its own and managed by the consultants?

A. In those days it would have been very much a medical model of care and most professions in those days acquiesced to medical staff. You know, behaviour modification by its very nature is a medical model of care. So they would have I think -- again not having worked there -- but they would have I think worked very much as part of that integrated team.

I think the DANO's report demonstrates that there was a professional line management arrangement, because it is the profession went in to do that investigation and query any subsequent action thereafter, but it would have been very complicated for the staff, so it would, because you had these multiple reporting arrangements, so you had.

Q. Okay. Thank you very much.

A. Okay.

MR LANE: Would the head of the unit have any other responsibilities, the nursing head?

A. Not that I am aware of. General management hadn't hit

us quite in Northern Ireland at that stage. So I doubt very much if they had managerial responsibility for clerical staff or support services staff. I don't know that for sure, but it wouldn't have been my assumption that they would have had.

Q. Right. It was mentioned that there was no Adolescent Psychiatric Unit for the older teenagers.

A. At that point in time, yes.

Q. Yes. So where would they have gone? Into adult wards?

A. Probably some of them into adult wards. Now this is me -- you know, there may well have been a facility that I don't know about. I'm just trying to explain why people would have ended up coming into Lissue at the sort of age of 15, 16. There would have been a history in Northern Ireland of some children, particularly those older children, going into adult wards.

Q. Uh-huh. Right. The staffing levels you mentioned --

A. Uh-huh.

Q. -- were virtually a tripling of the number of staff.

A. Uh-huh.

Q. I would be grateful if you would say a bit more about that, because the recommended level now is virtually one nurse per patient at any one time.

A. Yes.

Q. Is that really needed, that level of staffing?

A. Yes, for interventions to be therapeutic. We have -- I mean, child psychiatry and mental health services in Northern Ireland have always been the Cinderella service --

Q. Yes.

A. -- so they have. I think since the Bamford review was done things have changed significantly, but they have a lot of ground to catch up on. I think now the specialist unit at Beechcroft is seen as, you know, a tier 4 intensive care child and adolescent psychiatry unit and it is staffed appropriately. I think the work they do is amazing. I think we care for many more children at home in a supportive way. So the need for hospital intervention I think has reduced, and I think our social care colleagues have many, many more tools in their arsenal in terms of supporting those challenging children, but perhaps who do not have a mental health difficulty, who therefore would require an in-patient facility.

I think what we do now -- I mean, as part of this process for me in preparation for this Inquiry, you know, I have looked at what training now happens. It is safeguarding training; it is care coordination training; it is managing relationships boundary training; it is formal observations training; it is consent and capacity

training; legal framework training; rapid tranquillisation training; and breakaway training, and more.

So I think in the same way that we have learnt from inquiries like this, reports, reviews, the services have changed, very much so in child and adolescent psychiatry, but also in the total framework we have in the Health Service in Northern Ireland for governance.

Q. And the implication, if you say that that staffing is actually needed, is that they were under very much more pressure when they had the reduced level?

A. Yes, but remember they were of their day.

Q. Yes. Sure.

A. In 1979 or 1980 as a third year student nurse I was left in charge of an A&E Department at night and told to phone the Staff Nurse if I had a problem. You know, it was of its day --

Q. Yes.

A. -- and I think we just need to remember that, but I think the occupancy level going up, the complexity of need going up certainly must have caused nurses problems.

Q. Okay. Thank you.

A. Thank you very much.

CHAIRMAN: Well, Mary, thank you very much. That's the last

question we have for you. I hope this will be the only occasion we need to speak to you, but depending on the outcome of your searches for that report in the Public Records Office, no doubt it will be sent to us, of course, with I hope an additional statement --

A. Uh-huh.

Q. -- setting out whatever the Board's position may be in the light of whatever is in that. If that's the case, we may or may not require to see you again, but in any event I hope we don't, but thank you very much for coming today.

A. Okay. Thank you very much.

(Witness withdrew)

MS SMITH: Chairman, that concludes today's evidence.

CHAIRMAN: Well, we will adjourn until tomorrow.

(3.30 pm)

(Inquiry adjourned until 10 o'clock tomorrow morning)

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I N D E X