THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

MODULE 13

CLOSING WRITTEN SUBMISSIONS FOR

THE HEALTH AND SOCIAL CARE BOARD

AND

PUBLIC HEALTH AGENCY

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1. INTRODUCTION

1.1 The Inquiry is tasked to investigate historical institutional abuse and examine if there were systemic failings by institutions or the State in their duties towards those children in their care between the years of 1992 - 1995.

1.2 In Module 13, the Inquiry has heard evidence in respect to Lissue Hospital.

1.3 The Health and Social Care Board (HSCB) and Public Health Agency (PHA) has confined it's written submissions to the following:

1. Background;
2. The Applicants;
3. Nursing
4. Reports on Lissue

1.4 In extracting these issues the HSCB and PHA have sought to address key issues that were the subject of investigation in Module 13.

1.5 If the Inquiry has any further issues outstanding for the HSCB and PHA as a result of evidence heard in this Module, the HSCB will respond accordingly. For the purposes of these submissions, all references to the HSCB should be read as incorporating the PHA.

2. BACKGROUND

General

2.1 Lissue House was a private home to Colonel D C Lindsay. Its first link with the Royal Belfast Hospital for Sick Children ("RBHSC") was during the second World War when Colonel Lindsay offered accommodation at his home to give as many children as possible care and safety at the time of the first bombing blitz in Belfast.

2.2 On 1 May 1947, Lissue House was donated by the Lindsay family to the Royal Belfast Hospital for Sick Children (RBHSC). The first patients were admitted on 1 September 1948 and by 1959, Lissue was a busy branch hospital of RBHSC, treating surgical and medical patients.

2.3 A psychiatric in-patient service for children and young people was provided on the Lissue site from May 1971, with the first patients admitted on 17 May 1971 as detailed in the in-patient admission book. The Child Psychiatry unit at Lissue also offered day patient admissions. It is noted that the day patient admission book records the first patients for this service in September 1971.

2.4 From May 1971, therefore, there were two inpatient services at Lissue Hospital:

a. A Paediatric Unit in the ground floor comprising 20 beds.

b. A Child Psychiatry Unit comprising 20 beds and 5 day-patients providing specialist help to specialist help to children and families with emotional and behavioural disturbance.

2.5 In 1976, Lissue began admitting parents of selected young children with difficult behaviour problems in order to provide them with intensive

coaching in behavioural management techniques. These admissions were to a self-contained flat on the suite and they were usually time limited to approximately 2 – 3 weeks.

2.6 In 1978, Family Therapy was introduced and developed by Dr. Nelson and became an important part of the therapies in place at Lissue. This involved meetings with the entire family, including the patient, in an effort to seek out strategic solutions for the problems.

2.7 The Child Psychiatry Unit continued to operate at Lissue Hospital until 29 February 1989 when the services transferred to the Forster Green Hospital site, Saintfield Road, Belfast becoming part of the Green Park Trust.

2.8 The Paediatric Unit continued to operate at Lissue Hospital until the service transferred to refurbished accommodation at Belvoir Park in January 1989. It was renamed Forest Lodge Children's Respite Care Unit and became part of the Green Park Trust.

2.9 Lissue Hospital was not a purpose built unit, rather that it was a former family home converted for the purpose. As the Inquiry has heard, the building in itself gave rise to difficulties in the management and supervision of patients.

Administrative Structure

2.10 Prior to 1973, Lissue operated under the authority of the Northern Ireland Hospitals Authority who reported to the Ministry of Home Affairs. From 1 October 1973, Lissue Hospital was the responsibility of the Eastern Health and Social Services Board.

2.11 In his book entitled "*The Royal Belfast Hospital for Sick Children: A History*

1948-1998", Mr. Love said that the event which caused most concern and dismay to the staff was the transfer, in 1973, of the administrative control of Lissue Hospital from the North and West Belfast District to the Lisburn District.

2.12 As explained by Mr. Love in his book, Lissue was located within the Lisburn Health and Social Services District and although it was generally felt that Area Boards should be responsible administratively for all the facilities within their area, the Department of Health nevertheless recognized that there were special cases, such as Lissue hospital, where for very specific reasons, the administration should continue to be the responsibility of a District other than one in which the facility exists. However, in the case of Lissue, it seems that the Board decided upon arrangements, whereby Nursing Services were administered by Lisburn Health and Social Services District, Medical Services were administered by the Royal Hospital and the administration of the Social Workers remained with the North and West Belfast District.

2.13 This led to complex administrative arrangements, the outworking of which is described by Dr. McAuley in paragraph 7 of his written statement:

"*There were a number of issues concerning day to day running of the Unit which caused concern…The interests of different line managements resulted sometimes in a lack of empathy with the overall purposes of the Unit. As already mentioned – issues regarding the building were dealt directly by E.H.S.S.B, medics were the responsibility of E.H.S.S.B., Social Workers were managed by N. and W. Belfast Trust, Nurses were managed by the Lisburn and Down District, and psychologists by the Royal Group of Hospitals Trust. The different Trusts were always looking to cut staff – in other words there was little cohesive caring for our service, as might have occurred if we had operated under one Trust.*"[1]

[1] LIS 484

2.14 In her evidence to the Inquiry on Day 100, Mary Hinds, Director of Nursing in the Public Health Agency also said that a consequence of the complex administrative structure was that

"…you had a multiplicity of accountability lines, communication lines, information lines and therefore…you had no one organization 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…who work together in the best interests of the patients that they serve. I think the managerial and organizational arrangements that Lissue through this period had to work with didn't help them make that happen …[the]total picture could be missed because there was no-one with overall control, as it were. 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?"[2]

2.15 Mr. Love commented that, "*with hindsight, the decision to remove administrative control of Lissue Hospital from the North and West Belfast District of the EHSSB, whilst leaving the responsibility for patient care in the hands of Medical Staff of the Children's Hospital, looks very much like a triumph of bureaucracy over common sense*"[3] With the benefit of hindsight, the HSCB acknowledges that the administrative arrangements for Lissue were not ideal for the reasons outlined by Ms. Hinds and Dr. McAuley in their evidence.

Day to Day Running of Lissue

2.16 Lissue Child Psychiatry Unit had a multi-disciplinary ethos.

[2] Day 200, pages 91-92
[3] LIS 817

2.17 Children and Young People were in the main referred from the Out – Patient service at the RBHSC and other significant referrals came from Social Services. The referrals reflected a wide range of problems including behavioural problems, emotional disorders including, school refusal, anxiety, depression, self–harming, anorexia nervosa, encopresis and enuresis. The Child and Adolescent Psychiatrists were responsible for evaluating and accepting referrals for treatment in Lissue.

2.18 As set out in Dr. McAuley's witness statement, the inpatient unit mainly functioned on a Monday to Friday basis. Children remained at the weekends only under exceptional circumstances. Reasons for this may have included cases such as anorexic patients, who had not reached agreed target weights, patients who were regarded as being at a high risk of self harm, and also other who remained for reasons relating to family circumstances.

2.19 The evidence is that, as with any hospital, there was a routine to life for patients in Lissue. The average day usually took the following course:

a. The day began with the nursing handover when events of the previous shift were discussed.
b. After breakfast children in middle age group attended a morning meeting which was run by nursing staff. The meeting was used to review the previous 24 hours and to attempt to resolve any untoward issues between the parents. On other occasions the meetings were used to explore the use of problem - solving and social skills.
c. During the school day most children attended school during normal school hours. Breaks times were supervised by nursing staff.
d. Following school, children were separated into roughly groups by age, and were supervised by nursing staff.
e. Parents were encouraged to visit in the afternoons after school. The unit minibus was available to transport parents from R.B.H.S.C. to Lissue.

f. During each day, individual patients were seen for counselling either on their own, or with parents and the wider family and specific treatments for patients with certain disorders were managed such as dietary programs for anorexic patients, toileting regimes for children with encopresis and/or enuresis.

2.20 The evidence is that on one morning each week, each Consultant met with the whole Multi Disciplinary Team to review progress for each patient and plan for continued treatment. According to Dr. McAuley, he also frequently worked alongside other staff in parent child management programs. Dr. Nelson recalled visiting the unit daily to gain an impression of what was happening in the unit[4]. It is also clear from the contemporaneous records that the Consultants were 'on call' and responded to nursing queries about certain treatment regimes. A medically qualified psychiatric trainee also worked in the Child Psychiatry Unit on a full time basis and normally each trainee remained for a 6-month period.[5]

2.21 Most of the witnesses who gave evidence in Module 13 confirmed that staff were known by their first names and did not wear a uniform. In the HSCB's submission, this was in an attempt to break down barriers between patients and staff and to create a caring environment for the children and young people who were being treated there.

Concluding Remarks

2.22 Fundamentally, it is submitted that in evaluating the evidence and care provided at Lissue it is necessary to look at the full context. This is important from the perspective that this was a hospital, with the day to day care provided to the children by nursing staff who were qualified and

[4] Day 201, Page 132, line 19 – Page 133, line 2
[5] LIS 481, paragraph 3.5.3.

registered within their profession. The fact it was a hospital is also relevant to the duration of admissions for children. Unlike residential children's homes being considered by this Inquiry, children were admitted for periods of limited duration necessary to assess and treat their needs. They were also, in the most part, children who remained in close contact with their families, who took an integral role within treatment programmes in Lissue's psychiatric unit. Finally, alleged actions by staff can only be understood when placed in the context of any diagnosis or treatment plan implemented for that particular child.

3 THE APPLICANTS

3.1 There were 10 Applicants in Module 13, one of whom is deceased.

3.2 Two of the Applicants, HIA 404 and HIA 172, gave evidence about their time in Lissue Hospital Paediatric Ward.

3.3 The remaining Applicants had all been in patients in Lissue Child Psychiatric Unit and gave evidence about their experiences there.

3.4 Analysis of the admissions book for the Child Psychiatry Unit at Lissue shows that between May 1971 (opening) and 29 February1989 (date of closure) 1,124 children were admitted as in-patients and between the same dates 250 children were admitted as day-patients.

3.5 The number of Applicants who make complaints about their time in the Child Psychiatry Unit in this Module, 8 of which relate to the Child Psychiatry Unit represents less than 1% of children admitted to the inpatient unit over its 18 years of operation between 1971 and 1989.[6]

3.6 The admission book for the paediatric ward at Lissue has not been found. However, Dr Harrison statement for Module 13 states that the annual statistics for the whole of Lissue hospital which were published by the DHSS between the years 1966 to 1989 show total inpatient admissions of between 201 and 501 children per year and between 290 and 1760 day patient attendances annually[7]. As already noted, the inquiry has heard from just two Applicants in respect of the Paediatric Ward. As a minimum, Dr Harrison's statement suggests admissions of over 4,500 children during the 23 year period referred to. Thus it is submitted that the overwhelming

[6] LIS 081, paragraph 14
[7] LIS 793, paragraph 2.2

experience of children admitted to the Paediatric Ward was not one that gave rise to complaint.

ANALYSIS

3.7 In *Gestmin SGPS SA v Credit Suisse (UK) Ltd & Anor* [2013] EWHC 3560 Leggatt J said the following about testimony based on memory at paragraph 15:

"*An obvious difficulty which affects allegations and oral evidence based on recollection of events which occurred several years ago is the unreliability of human memory…Memory is especially unreliable when it comes to recalling past beliefs. Our memories of past beliefs are revised to make them more consistent with our present beliefs. Studies have also shown that memory is particularly vulnerable to interference and alteration when a person is presented with new information or suggestions about an event in circumstances where his or her memory of it is already weak due to the passage of time.*"[8]

3.8 Given the fallibility of human memory as outlined by Leggatt J in the passage above, it is submitted that examination of the contemporaneous documents should be of significant assistance when considering the Applicant's oral and written evidence and their beliefs about what happened to them in Lissue.

3.9 In one of Lord Bingham's essays in "The Business of Judging"[9], he quotes an extra-curial speech by Lord Justice Browne, who makes the same argument as Leggatt J, when he says "*The human capacity for honestly believing something which bears no relation to what actually happened is unlimited*."

[9] The essay is entitled "The Judge as Juror: The Judicial Interpretation of Factual Issues".

HIA 404

3.10 HIA 404 had two inpatient hospital stays. It seems that the first of these was to Lissue Paediatric Ward when just 22 months old[10]. Contemporaneous records show that HIA 404 had a second in-patient admission but it is unclear whether this was to Lissue. In his evidence on Day 196, HIA 404 candidly acknowledged he had a definite recollection of leaving Crawfordsburn hospital and his memories of physical abuse could have related to his time in Crawfordburn[11]. It is submitted, however, that given HIA 404's very young age during his admission and the length of time that has since passed, very little weight ought to be attached to HIA 404's recollections.

HIA 426

3.11 HIA 426 was an inpatient in Lissue Paediatric Ward sometime between [redacted] and [redacted]. Despite extensive searches, the admission and discharge book for the Pediatric Ward has not yet been found. Nor has any contemporaneous records relating to HIA 426 in Lissue. HIA 426 recalls inappropriate sexual advances by a male nurse. On Day 197, HIA 426 said "*I remember thinking it wasn't right. He shouldn't be doing that. So I was old enough to realise that, but at the same time I do remember clearly saying, "If I tell on him, he'll get into trouble.*"[12]

HIA 421

3.12 HIA 421 was aged [redacted] years when she was admitted to the Child Psychiatric Unit at Lissue. HIA 421 described being restrained and she said that the

[10] Day 196, Page 6, lines 7-12 "*So that would seem to suggest that you were in Lissue from 1st August [redacted] until June [redacted]. So you were there between he ages of [redacted], until you were [redacted] months old,* [redacted] also see LIS 45053
[11] Day 196, Page 8, lines 2-13; and Page 18, lines 1-5
[12] Day 197, Page 62, lines 12-16.

staff in Lissue were violent. HIA 421 described the staff as very strict and very cold and she recalls bring left in her room "all day". HIA 421 also said that staff refused to change her wet bed and described how she was left in a wet bed and wet underpants "for days" and had to sleep on the floor when her bed was wet.

3.13 There are no contemporaneous records relating to HIA 421's stay in Lissue. The HSCB accepts that HIS 421 may well have perceived staff to be strict and cold. It is also known that restraint was used in Lissue, a topic which will be discussed later in this submission. However, HSCB does not accept that staff were violent towards HIA 421 or that nursing staff refused to change her wet bed or underpants or that she had to sleep on the floor when her bed was wet.

HIA 220

3.14 HIA 220 was admitted to Lissue for an eight-month period between November [redacted] and June [redacted] for 'intensive therapy treatment' although he had home leave at the weekends. It is also known that HIA 220 had two episodes of day patient treatment in Lissue in [redacted]. HIA 220 alleges that he was indecently assaulted and raped by LS 21 and, on a subsequent occasion, he was raped by LS 21, LS 26 and LS 27 who were acting in a joint enterprise. The police have investigated HIA 220's allegations against LS 21 but no prosecution has been directed. He also alleged physical abuse by LS 22 and LS 23 and recalls being put into the corner for 45 minutes.

3.15 HIA 220's allegations against LS 21, LS 26 and LS 27 are of an extremely serious nature. The HSCB notes that the police have investigated the allegations against LS 21 and no prosecution has been directed. Contemporaneous records are available but they offer no indication of what HIA 220 now complaints about.

3.16 Some records suggest that HIA 220 is mistaken in his recollection about some matters. For example, HIA 220 was firm in his belief that there were no glass panels in the doors[13]. However, a DANO report dated 16 March 1983 confirms that "all bedrooms have glass panels in doors."[14] This is an important fact as HIA 220 is alleging that LS 21 raped him in his dormitory and LS 21 made the following point during his police interview:

"*The route between any such bathroom and his dormitory involved the passing of three four-bedded dormitories. Dormitories had glass windows in the doors and therefore movement would have been visible. If any allegation relates to day time, staff would have had -- would have to have passed through a busy and occupied room to get to [your] dormitory, assuming that [you were] in the eight-bed dormitory [which HIA 220 was*]"[15]

3.17 In paragraph 9 of his written statement, HIA 220 states he believes "other staff members knew what was happening, but they turned a blind eye". In his oral evidence, he further commented that 'it was quite easy in the 1970s to turn a blind eye because The Troubles of Northern Ireland were in full flow."[16]

3.18 The HSCB does not agree. Had staff been aware of the alleged sexual assault of HIA 220, the HSCB would expect to see some reference to this in the contemporaneous records that exist in relation to him. In addition, the HSCB would expect that staff who knew about sexual abuse of patients, would in all likelihood have reported any incident to line managers, field social work colleagues and/or the police, as happened in the cases of LS 71

[13] Day 197, page 33, lines 14-15
[14] LIS 1416
[15] Day 197, page 33, lines 8-15
[16] Day 197, page 37, lines 17-19

[redacted] and LS 68 [redacted]. Nursing staff were also subject to a professional code that required them to report professional misconduct.

HIA 172

3.19 HIA 172 had 11 admissions to Lissue Child Psychiatric Unit between [redacted] and [redacted]. He was under the care of Dr. R McAuley and, on Day 197, HIA 172 said the following about Dr McAuley's role, "*He only administered it. He didn't actually – he delegated it. He didn't actually do it himself. It was delegated to staff members on the unit. I think maybe if he did it himself, it might have had some effect, but...*"[17]

3.20 Lissue was a Consultant-led Unit. This means that the Consultant Child and Adolescent Psychiatrists led the multidisciplinary team which implemented the clinical treatment plan for the patient. The evidence is that the Consultant Child and Adolescent Psychiatrists attended the hospital for weekly ward rounds and, in addition to this, they also worked directly with patients and their families. However, the contemporaneous records and evidence of staff who worked in Lissue, shows that much of the individual patient's treatment plan was carried out by nursing staff in conjunction with other members of the multidisplinary team, including LS 80 [LS 80] and the psychologist who worked on site.

3.21 HIA 172 makes allegations of assault by LS 7, LS 6 [LS 6], LS 84 [LS 84], LS 5 [LS 5] and LS 8 [LS 8]. He also alleges emotional abuse by LS 7 and LS 6 and he recalls being placed in isolation for prolonged period of time, either in his pajamas or naked[18].

[17] Day 197, page 76, lines 12-16
[18] Day 197, Page 125, lines 14-21

3.22 In respect to his being isolated, the HSCB does not accept that HIA 172 would have been naked. In addition, it is important to observe the context for HIA 172's treatment plan. In May [redacted], HIA 172 was placed on suicide caution card after going onto the hospital roof and absconding. LS 8 wrote to the Director of Nursing Services on 24 May [redacted], saying:

"*... after a morning of intermittent disturbed behaviour. He was aggressive to personnel and property. Nursing staff following medical instructions of low profile surveillance, this being the recommended treatment for HIA172 over the past few weeks when he manifested very similar behaviour. After this morning's events medical staff have decided to place him on suicide caution card, i.e. constant observation when he returns from this abscondment. Immediately prior to this medical action I instructed nursing staff, Child Psychiatry Unit, that until further notice from myself or my deputy that nursing staff keep him under constant observation irrespective of whether medical staff recommended this or not. I take this course of action because I would be anxious of the child bringing harm to himself, other people or serious damage to property. I will review the situation when I return from study leave in two weeks' time.*"

3.23 In the HSCB's submission, this document evidences that although HIA 172 perceived his treatment to be unfair and arbitrary, the decisions made about his needing constant supervision were made in his best interests, as there was professional anxiety that he would harm himself or other people or cause serious damage to property.

3.24 There are no contemporaneous records in respect of HIA 172's complaints of physical assault by nursing staff. Nor is there any recording of a head injury that HIA 172 claims he sustained at the hands of LS 8. LS 8 is deceased and LS 7, who is the only nurse complained about by HIA 172 and who gave evidence to the Inquiry, denies the allegations of physical assault. Thus, there are real factual disputes and, in the HSCB's submission, it is not

possible on the basis of all the evidence currently available to establish the facts of what happened.

3.25 HIA 172 also complains about emotional abuse by a number of nurses. There are some contemporaneous records in May [redacted] that reference HIA 172 rationalizing his disturbed behaviour because staff were saying his parents "*don't look after him properly*"[19] and he felt they were implying "*they don't care about him*"[20]. Whilst the HSCB accepts that it would be wrong and unacceptable for staff to goad HIA 172 about such matters, it cannot be sure that these notes reflect inappropriate communication by staff. For example, it could be that issues such as his relationship with his parents was legitimately and appropriately discussed with HIA 172 but his perception of the situation, as a 12 year old boy, was different.

HIA 294

3.26 HIA 294, now deceased, was an in-patient in Lissue for four months in [redacted] when he [redacted] years old. When talking to the Acknowledgement Forum, HIA294 did not allege that he was abused in Lissue. Rather, he remembered being turned over on his stomach and someone being near or working around his bottom. He explained that he had subsequently asked himself whether or not he was sexually abused in Lissue?

3.27 A psychology report compiled shortly before HIA 294's admission to Lissue references that he had severe encopresis[21] and, as suggested by Mr. Aiken BL on Day 197, this most likely indicates that HIA 294 was receiving assistance for a medical condition "*and that's the memory that he had, which*

[19] LIS 1343
[20] Ibid.
[21] LIS 691

would allow him then to answer his question of was he or wasn't he with the more likely he wasn't answer."[22]

HIA 38

3.28 HIA 38 was an inpatient in the Child Psychiatrist Unit at Lissue between November [redacted] and July [redacted] when he was aged [redacted] years. HIA 38 recalls being made to smoke; being locked in at night; being locked in a room with bars on the window if he was badly behaved. The report written in 1983 by the DANO[23] and the Mental Health Commission report dated do not mention bars on the windows and no other witness recalls bars on the windows of Lissue hospital. The HSCB does not accept that HIA 38 was made to smoke or that he was locked in a room with bars on the window.

3.29 HIA 38 complains that LS 7 called him a '*stupid bastard*' and slapped his face when trying to take blood from him and he recalls blood *'went all over her white coat.*' As nursing staff in Lissue wore ordinary clothes, the 'white coat' memory is, in the HSCB's view, misplaced. In addition, there are no contemporaneous records of such a struggle with taking blood] and LS 7 denies that the allegations made against her.[24]

3.30 In paragraph 14 of his witness statement, HIA 38 refers to a record dated March [redacted] which states, *inter alia*, "..[*HIA 38] seems to watch staff through play as if he was afraid of doing something wrong or turning his back in case he would get a slap…*"[25]. HIA 38 says this entry "show that staff hit me otherwise why would I be in fear of getting a slap from staff if it hadn't happened before." On Day 198, HIA 38 said "*I was beaten my entire childhood*

[22] Day 197, page163, lines 7-20.
[23] LIS 1416
[24] A record, in adult medical records relating to HIA 38 which have recently been made available to the Board, states "phobia to needles". This record has been forwarded to the Inquiry under cover of correspondence dated 13 May 2016
[25] LIS 051-052, paragraph 14

and it was something I just grew used to."[26] "This disclosure reflects the history contained in the contemporaneous records and in the HSCB's submission, this may also explain the recording made in March [redacted].

3.31 HIA 38 also complains that staff did not intervene when he was hit by other children. The contemporaneous records record that peers did '*thump*' and '*kick*' HIA 38 on occasion. However, the records do not say what action, staff took. The nurses who gave evidence to the Inquiry, said that they did intervene when children were fighting and the HSCB believes that staff would have intervened and responded to fighting between patients. HIA 38's records also show that he had a poor relationship with his peers in Lissue and one document records that on one occasion each and every peer complained about him or told him to leave them alone[27].

3.32 HIA 38 also believes he was heavily drugged and misdiagnosed. On Day 198, he said of the staff in Lissue, "*They were just very, very bad people, so they were. In my case I should never have been there and they did get it wrong.*"[28]

3.33 In the HSCB's submission, there is no evidence to support these assertions. On the contrary, the evidence supports the view that the staff group in Lissue was committed and dedicated – there was a low staff turnover and many of those who worked there either still work in the field of Child and Adolescent Mental Health or did so until their retirement. The Inquiry will recall the evidence of LS 81 who, with some emotion, told the Panel "*I have been very distressed what I have read the reports that were shared with me, for that's not how I remember Lissue. There were many children and many families that were helped and certainly there were a lot of very good activities that happened in that unit.*"[29]

[26] Day 198, page 24, lined 11-13
[27] LIS 554
[28] Day 198, page39, lines 19-21
[29] Day 198, page 100, line 3-8

3.34 The following exchange between Ms. Doherty and HIA 38 also highlights how during his eight month stay he "*never witnessed any heavy abuse*":

Q…Could I just clarify when you talk of memories of hearing other children squealing, are you linking that to LS7 or are you saying that generally staff were rough with children?

A. In general.

Q. Generally they were. So it wasn't just about one member of staff, that there was general ...?

A. No. As I says, I never directly seen an awful lot of it. I seen the odd people getting slap, kicks and thumps and fighting among other people, but I never witnessed any heavy abuse.

Q. By anybody else?

A. By anybody else.

Q. So it was amongst children that you saw that?

A. I always heard it from a distance."

HIA 119

3.35 HIA 119 have evidence on Day 198. He was placed in Lissue for a period of six months during [redacted], when he was [redacted] years old. HIA 119 alleges that he was subjected to physical and mental abuse by three members of staff at Lissue. He also recalls two 'nice' members of staff who, he said, witnessed the abuse but they '*did not intervene or tell other staff to stop. All they did was stand beside me and say you'll be okay and they comforted*

me."[30] LS 81 was present whilst HIA 119 have his evidence on Day 198. LS 81 worked in Lissue during HIA 119's admission and she told the Inquiry she was surprised to hear the allegations about LS 34 as she was a former colleague and never witnessed anything of that nature.

3.36 Moreover, the following exchange between Ms. Smith QC and Nurse LS 81 shows that there was a positive duty on all nurses to report improper conduct to the regularly body:

"*Q. And you would have reported that if you had noticed that?*

A. Immediately, yes, not only just as a person, but as a nurse and a registrant my regulatory code, which is a public safety issue, expects me to identify acts or omissions, to actually report it to the now known as the NMC, but it would have then been the UKCC."[31]

3.37 It is the HSCB's submission that the positive duty on nurses to identify and reports nursing acts or omissions in breach of their regulatory code ought to have been a strong protective factor in upholding nursing practices in Lissue.

3.38 HIA 119 also alleged that he sustained two broken bones, one of which was deliberately inflicted by a member of staff stamping on his hand and the other sustained after the same staff member was recklessly spinning too fast and he fell off on roundabout. Whilst these injuries are recorded in the contemporaneous notes, there is no indication of who or what caused them. Nor has it been possible to identify the staff member named by HIA 119, who knows only his first name. In addition, the incident book as recalled by Dr McAuley, has not been

[30] LIS 002, paragraph 4.
[31] Day 198: Pg. 99, lines 18-25

located which may have provided further insight into the circumstances of HIA 119's injuries. In all these circumstances, the HSCB does not think it is possible to say who or what was responsible for causing HIA 119's injuries.

3.39 HIA 119 also recalls awaking at night and when he got out of bed he could never find a member of staff. LS 81 agreed that there was a chance that a child getting up at night might not have been able to locate staff, as evidenced by the following exchange with Ms. Smith QC:

Q. …. because of the layout of Lissue, it is possible that night staff, while obviously on duty, might have been doing something else when a child got up at night and he might not have been able to locate them?

A. *There is a chance of that, and certainly night staff would have -- some would have stayed downstairs with the children in the rooms downstairs and some would have stayed upstairs. I didn't do night duty, but it may have been."*[32]

3.40 However, it is also the case that the HIA 119's contemporaneous notes include sleep charts and Fortnightly Summary Reports which provide detailed accounts of his sleep patterns whilst in Lissue, which would suggest that nursing staff monitored HIA 119's sleep throughout the night[33].

HIA 3

3.41 HIA 3 was an in-patient in the Child Psychiatric Unit in Lissue between November [redacted] and February [redacted] HIA 3 went home at weekends. In his oral evidence on Day 199, HIA 3 said Lissue was like a '*concentration camp*'. He described staff shouting at him, grabbing him and he says he was mentally and physically abused at Lissue. He also says he was asked

[32] Day 198, page 91, lines 4-16
[33] LIS 1012 – 1020

personal questions about his sexuality and was asked if he masturbated. HIA 3 found these questions to be degrading. He also found the experience of family therapy to be humiliating and degrading.

3.42 HIA 3 recalls feeling '*belittled*' by a male nurse, LS 44, and a school teacher LS 1. Neither LS 44 or LS 1 has given evidence to the Inquiry and there are no records that corroborate HIA 3's complaints about physical abuse. In fact, the records show that HIA 3 did very well at school in Lissue and won a number of prizes. However, there is a record dated 3 December [redacted] that says HIA 3 was "*unable to share a joke with his peers and staff. He likes to sit and have a laugh at other peers but doesn't like the joke to be on him. Tonight staff teasing him and he was unable to take it. Ran out of the room and began to cry. When spoken to firmly he settled quickly. Parents and rest of family attended for family therapy.*"[34]

When this note was brought to Dr. McAuley's attention by Ms Doherty on Day 201, he immediately said "*I am not happy about that*"[35] and agreed with the Chairman that this did not seem a very helpful way to work with a child. The HSCB agrees with this and submits that it was not appropriate for staff to have teased a patient who was receiving in-patient treatment for anxiety related issues. However, the HSCB also submits that the full context may not be apparent from the notes.

HIA 251

3.43 HIA 251 was placed had two in-patient admissions to the Child Psychiatry Unit at Lissue. His first admission was between [redacted] and [redacted] and his second was between [redacted] and [redacted] HIA 251 recalls being strapped to a bed and being given injections regularly.

3.44 There is no mention of the use of straps in the contemporaneous records of

[34] LIS 20144
[35] Day 199, page 123, lines 2-18.

HIA 251 or any other Applicant. Nor are regular injections referenced in the notes. However, it is known that after climbing onto Lissue hospital roof and absconding, HIA 251 was put to bed on return and given an intramuscular Diazepam injection by LS 128, Senior House Officer. He was also constantly supervised by nursing staff and a behaviour programme was implemented to allow HIA 251 to earn his way out of his bed[36].

3.45 The contemporaneous notes show that the plan put in place for HIA 251 was devised by the Consultant Child and Adolescent Psychiatrists and it was implemented by nursing staff. The contemporaneous notes reference that, when HIA 251 was on the roof, the nurse in charge contacted Dr McAuley and Dr Nelson, who both attended the hospital and gave advice that HIA 251 '*was to receive no attention which might further aggravate the situation and were happy to leave the situation in the hands of nursing staff…*"[37] They also sh. that it was a doctor who administered the Diazepam injection.

CONCLUDING REMARKS

3.46 The HSCB is of the view that the nature of the behavioural management programmes in Lissue were such that they were perceived as harsh and unjustified by the Applicants. Practice at the time, as designed by Senior Clinicians was, however, driven by legitimate clinical objectives and goals with parental agreement and participation.

3.47 This is well demonstrated by what was said by one of the mothers involved in the BBC Horizon documentary who felt that the behaviour modification programmed worked quickly with her child and had she not seen it working she would have "*definitely scrubbed it, I would have thought it was too brutal, I think for want of a better way of describing it, it was like training a dog or*

[36] LIS 647
[37] LIS 645

an animal and for those reasons you sort of thought what am I doing, what am I doing to my son, you know and. it worked, it has worked and it has changed the child and it has changed me – it has given us both what we needed, freedom from each other and confidence in each other"[38].

3.48 The HSCB is also of the view that the nurses in Lissue were primarily responsible for implementing the behaviour mortification programmes and, as will be addressed, in Chapter 4 of these submissions, there appears to have been variations in practice about when and how to implement some of the techniques, as their implementation required a degree of discretion and the exercise of professional judgment.

3.49 As developed in Chapter 4, the HSCB also accepts that there may have been occasions when the behavioral management techniques were misapplied and may have gone beyond what was appropriate. The HSCB does not however accept that this extended to systematic abuse of children.

[38] LIS 116, paragraph 129

4. NURSING

4.1. In the HSCB's view, it seems that the nursing profession played a pivotal role in the delivery of services in Lissue. This is because although the treatment plan was drawn up as part of a multi disciplinary group which was led by the Consultant Child and Adolescent Psychiatrist, it largely fell to nursing staff to implement the plan and report back to the multi-disciplinary group at the weekly ward round meetings.

4.2. LS 81 recalls that she was allocated four patients and acted as 'key nurse' in respect of them, working alongside another nurse and a nursing auxiliary. She also recalls attending the multi-disciplinary meetings as a junior nurse reporting her observations and she said that senior nurses influenced the development of the plan at the multidisciplinary team meetings[39].

4.3. LS 81's written statement says "*my nursing code from the regulatory body expected me to report if I saw something/poor practice as a nurse*"[40] In the HSCB's submission, this is an important consideration because all nurses in Lissue would have been subject to the same code, as re-issued from time to time, this ought to have been a protective factor for safeguarding the welfare of patients.

4.4. LS 81 also said if she had seen any of her colleagues behaving inappropriately towards a child, she would have reported it[41] and, in paragraph 14 of her witness statement, she recalled "*There were some occasions where I observed what I believed was a misapplication of a behavioural technique, this was in relation to time out.*

[39] LIS 1197, paragraph 5
[40] LIS 1201, paragraph 17
[41] Day 198, page 101, lines 11-13

This had two aspects: first, a move to implement time out instead of using a diversionary technique and secondly, to extend the time the child was in time out. When I had such concerns I brought this to the attention of senior staff. This would then have been discussed with the nurse in question and I would have been aware of their practice modifying, thus resolving the issue. I did not consider this to be abusive practice, and never saw time out being extended to significant periods."[42]

TIME OUT

4.5. In the HSCB's view, the experience of LS 81 suggests that there was a variation in practice among the nurses in terms of how when and how they implemented particular behavioural management techniques that were prescribed for children as part of the multidisciplinary plan. The following exchange between Ms. Smith QC and LS 81 further supports this view:

Q…. in the police material one of the members of staff who was spoken to said that the older staff would have been firmer and stricter than the younger staff. Would that have been your experience?

A. Yes.

Q. And when we were also talking you talked about the distinction between using your discretion about going to time out or using a diversionary tactic, which would --in your case you would have assessed that on the basis of what risk the child was posing to themselves or to others.

A. Yes.

[42] LIS 1200

Q. I think when we were -- the expression that I used when talking to you about how a child would have been taken for time out … it was guidance rather than force that was used.

A. Absolutely, and that would have come from the training that I would have been exposed to. You know, it was definitely that it was meant to be a supportive activity, not a forced activity."[43]

4.6. The HSCB also considers that the nature of the behavioural treatment programmes and the exercise of professional judgment about when to begin and end techniques such as time out occasions may have led to inconsistency in practice and, on occasions, may have gone beyond what was appropriate.[44]

RESTRAINT

4.7. It is also clear that restraint was used in Lissue and that the use of restraint was approached differently by staff members. On Day 201, Dr McAuley told the Inquiry that "*… the first thing you've got to get right is what you actually mean by restraint*" and he gave two examples, which require different restraint techniques to be used:

"*If you are talking about a 5-year-old who is out of control…and he was in a full-blown tantrum and was damaging stuff and himself, then the best thing to do is to put the child on a parent's knee or on a nurse's knee and hold the child till the child calms down… With older children, that's your 10-year-old, who is in a much more difficult situation, where in order to manage them you have got to actually put them down on the floor and hold them down using a couple of members of staff."*[45]

[43] Day 198, page 1-1, lines 15-25 and page 102, lines 1-11
[44] Day 200, page 1881, lines 13-21 Question and Answer exchange between the Chairman and Mary Hinds
[45] Day 201, page 96, line 21 – page 97, line 1 and page 97, lines 6-10

4.8. In the HSCB's submission, this insight most likely explains the apparent dissonance in the evidence of LS 81 and LS 21 on the one hand and LS7 on the other. When asked about restraint, LS 81[46] and LS 21[47] described a 'holding' technique, similar to a hug whereas LS 7[48] described holding children down by the arms and legs on the floor or a bed. Applying Dr McAuley's analysis, both techniques may have been appropriate – it all depended on the circumstances, not least the age of the child.

4.9. The HSCB accepts, however, that the technique of restraint, like Time Out, was susceptible to different approaches from staff. In the HSCB's submission, the following evidence from Dr McAuley demonstrates the point well:

"*A: Well, the different approaches of staff … I think you have had LS21 talking. He would have been somebody who would have been much more able to talk to children when they would look as if they are getting into an out of control situation and maybe through that would have avoided it. There are other members of staff who are not as good as that and the situation blows and they get involved in a full restraint. Now you could say that's inappropriate in the fact that some staff members need to improve their skills in being able to talk children down …and that's the -- I suppose that was the realistic mix of staff over time…*

Q: I think just to be -- to descend into personalities, you would say that LS7 went straight to a management situation.
A: Would be more inclined -- I would have viewed more inclined to go straight to a management situation than take a long time -- not a long time -- you don't want to take too long -- just attempting to give the child the options to cool down, as it were."[49]

[46] Day 198, page 84, lines 9-24
[47] Day 199, page 48
[48] Day 201, see pages 16-19 for full discussion
[49] Day 201, page 98, lines 3-24

4.10. In the HSCB's submission, staff training is of the utmost importance . The nurses who gave evidence to the Inquiry recalled training on restraint[50] and LS 7 explained this by saying she was trained in the use of restraint by watching other nurses on the job. LS 80, who was the Senior Social Worker working in Lissue, also said he "was never formally trained how to do it…in *those days we basically watched other people do it and modelled our behaviour on that*"[51].

The evidence of LS7 and LS 80 chimes with Dr McAuley's recollection that in the 1970s "*a lot of things were learnt just by observing other people*". Dr McAuley also acknowledged that "*training … was not in those days as sophisticated as it was, say, in the Forster Green days, when there were occasions during each year – there would have been full days or half-day sort of workshops on doing restraint.*"[52] The Board submits that Dr McAuley's evidence reflects that training programmes for health and social care staff developed over time.

4.11. In the HSCB's view, the state of affairs regarding staff training on restraint in Lissue is most likely a reflection of and in keeping with general standards and practices at the time.

SEDATION

4.12. The Inquiry has made it clear that it is not within its remit to examine the medical treatment given to patients[53]. However, Applicants Christopher Donnelly and HIA 251 have complained about being injected regularly and being heavily sedated. In the HSCB's submissions, it is outwith the remit of

[50] For example, on Day 198, LS 81 said when she went to Lissue, she was taught about holding [see page 84, lines 9-4] and on Day 199, LS 21 said he had some training on restraint [see page 48, lines 11-13]
[51] Day 200, pages 63, lines 9-25 and page 64, lines 1-11 for a full discussion
[52] Day 201, page 97, lines 11-20 for full discussion
[53] Statement of Sir Anthony Hart, Inquiry Chairman, dated 4 November 2015

the Inquiry to investigate either of these complaints, as to do so would require detailed analysis of their medical treatment including prescriptions and the medical reasons for them.

4.13. Many of the witnesses who have worked in Lissue have been asked about the degree of discretion given to nurses to administer medication and injections to patients.

4.14. Dr McAuley said:

"…If children needed medication, whatever it was, it was written up on the Kardex as to whatever it was, with the dose and the frequency, and that was what would have been given to children. Now I -- they weren't given any license to have free rein with using medication.

Q. Was there a possibility … I think it was LS21 who actually told us there was prescribe as necessary".

A. Okay. That's a different form of prescription and that opens the thing a little.

Q. That would have allowed a nurse in a given situation –

A. A given situation.

Q. -- to be able to give medication –

A. Yes, yes, yes. That's right.

Q. -- whether by way of injection or liquid medication.

A. Well, I don't think by injection. I mean, nurses these days can give injections. In those days –

Q. They didn't?

A. ---that wasn't the case.

Q. There were, however, registrars on site who could have given injections.

A. During the day, yes."[54]

4.15. During his evidence LS 21 was told about records regarding HIA 251, who was sedated after he climbed onto the roof and was asked about the position was with regard to sedating children he Lissue[55]. This is what he said:

"That potential behaviour would have been evaluated and assessed and pre-determined at our meetings and some contingency plans had to be put in place or set up in order to respond. I'm worried about the word "discretionary", although I suppose strictly I [sic] interpreted that as, if needed, it has to be given but that would have been already designed by the consultant.

Q. So if I've understood our discussion earlier correct … because -- but the situation was that a child's treatment plan would have been in position, as it were, for the child … and that might have included "Sedate as required" –

A. Yes.

Q. -- based on what was known about the child's behaviour and whether that might prove to be necessary. I think one important point is that it wouldn't have been a reaction to a behaviour. It would have been in order to prevent or ameliorate a difficult situation. You wouldn't want to sedate a child who is already sedated and

[54] Day 201, pages 99 and 100
[55] Day 199, page 46

settled. Sedation was only used if a child was completely out of control and had injured himself or others."[56]

4.16. In HIA 251's case he and another boy climbed onto the roof of Lissue hospital on [redacted] , placing himself, other patients and staff at risk of serious harm[57]. The contemporaneous records show that Dr Nelson was contacted, attended the hospital, spoke with social work and nursing staff, drew up a action plan and spoke with HIA 241.[58]

4.17. Then on [redacted], Dr McAuley wrote to LS 8, who was the Nursing Officer, setting out a detailed action plan if HIA 251 were to go onto the roof again.[59] As part of the action plan, Dr McAuley wrote:

"*Following any episode in which the child goes out in to the roof and late comes down my onion is that he should be given a tranquillizer in the immediate phase and this hopefully also allow the situation created on the ward to settle down. Following this then a programme in which the child earns his way out of the room should be instigated. This has already been discussed with staff at Lissue and I hope they would take this as their responsibility to design."*[60]

4.18. Dr McAuley's action plan was implemented on [redacted] when HIA 251 managed to get onto the roof again after squeezing through a small window in the toilet.[61] The steps taken by nursing staff are fully documented in the in-patient nursing notes. It is clear from these records that among those contacted by the Nurse Manager was LS 142 , [redacted] who checked that Dr McAuley's plan was being

[56] Day 199, pages 46 and 46
[57] LIS 629, nursing notes dated 14 May 1986
[58] LIS636-637
[59] LIS 633-634
[60] LIS 633-634
[61] LIS 641

implemented. The notes also show that LS 142 and Dr McAuley later attended the hospital and that:

a. HIA 251 received Diazepam intramuscularly by LS 128 Senior House Officer "*on Dr McAuley's instructions giving us time to bring the unit back into its full routine.*"[62]

b. Dr McAuley had requested that the child was given the tranquiller to relieve nursing pressure;[63]

c. A second injection intramuscularly of Valium was given by LS 128 – HIA 251 remained elated with pressure of talk and asking if the nurse '*would observe him if he went asleep in case drug damaged his brain as he had glue sniffed.*'[64]

In the HSCB's submission, HIA 251's notes do not support a view that he was injected regularly or that nursing staff were given wide discretion to administer prescribed medication.

4.19. Rather, the notes show that the sedative injection was administered by a Senior House Officer on foot of express medical advice and a detailed plan drawn up by the Consultant in overall charge and that this was in response to a serious situation when HIA 251 had been behaving dangerously and presenting a risk to himself and others. At this remove, there may be concern about the note that the child was given the tranquilliser in this instance to '*relieve nursing pressure*'. The HSCB submits that this note should be read in the context of the evident risk posed by the behaviour of HIA 251 to himself, other patients and staff on the Ward. By administering a sedative, those risks would be reduced and the Ward would be brought back under control.

4.20. The Inquiry has also raised a query about some of the entries on HIA 172's notes contained on pages LIS 1341 and 1343 of the bundle. The injection

[62] LIS 646
[63] LIS 649
[64] LIS 653

chart on LIS 1341 has two sections – one entitled 'regular injections' and another entitled 'once only injections'. Both sections have an entry dated [redacted] Valium 5 mg although the entry under 'regular injections' says in light of the entry "*if needed to repeat (phone first)*".

4.21. The HSCB considers, in hindsight, that the direction in the Kardex on LIS 1341 is not clear because the entry in the 'regular injection' section could be interpreted as one which followed the stat dose recorded in the 'once only injections' section. In the HSCB's view, it could also be interpreted as meaning that nursing staff had authority to administer 5mg VALIUM IM if they assessed it was needed on subsequent occasions/dates but, if that dose had to be repeated, nurses would be required to phone the doctor first. The doctor would then make an assessment if the medicine should be administered or if an alternative treatment/medication should be considered.

4.22. The HSCB also considers that the doctor's note at LIS1343 concurs with the medication chart and would have been accepted practice at the time. The doctor's notes at LIS 1343 also show that it was a doctor, who was present when HIA 172 was wrecking his room and breaking glass on [redacted], that ordered IM Valium 5 mg for the patient.

4.23. To conclude, the HSCB does not believe that the entries in the notes of HIA 172 show that nurses were given undue discretion about when to the administer sedatives to patients. Rather, the notes of HIA 172 and HIA 251 support. Dr. McAuley and LS 21's evidence that the decision to administer a sedative injection was medically led; that communication took place between doctors and nurses before a sedative was administered; and that, in Lissue, doctors gave sedative injections, which was in keeping with practice generally at the time, although as mentioned by Dr. Nelson in his evidence

sometimes nurses may have had to give injections at night "*but injection wasn't a very common way of administering drugs or necessary even*.[65]

[65] Day 201, page 146, lines 19-20.

5. REPORTS ON LISSUE

Inspections

5.1. The Ministry of Home Affairs (MOHA) had a power of inspection concerning any hospital pursuant to section 63 of the Health Services Act 1948. This included a power of entry to inspect which is similar in terms, albeit it not identical, to the Ministry's powers of inspection in respect to Children's Homes as contained in section 102 of the 1950 CYPA and section 168 of the 1968 CYPA.

5.2. The power of the MOHA remained *in situ* until the re-organization of health and social services on 1 October 1973 by virtue of the provisions of the Health and Personal Social Service (NI) Order 1972, section 50 of which gave the MOHA a power of inspection in relation to "*any home for persons in need or other premises in which a person is or is proposed to make arrangements made by the MOHA*".

5.3. Despite the statutory power, no records of inspection by the MOHA or the Department of Health have been found in respect to Lissue Hospital. When giving evidence on Day 201, Dr. McAuley recalled Departmental inspections of Lissue[66] although Dr. Nelson did not recall the Social Services Inspectorate or the Social Work Advisory Group coming to Lissue[67] . Dr McCoy has subsequently filed a statement which says that, at no stage during his employment with SWAG or SSI, was an inspection carried out at Lissue.[68]

[66] Day 201, page 101, lines 10-25 and page 102, lines 1-2.
[67] Day 201, page 149, lines 14-17
[68] LIS 1450

DANO Report (1983)

5.4. In March 1983, the District Administrative Nursing Officer carried out an investigation and completed a report on the nursing service in the Child Psychiatrist Unit of Lissue. The investigation was carried out immediately after an allegation of peer sexual assault had been made by a former patient who had stayed in Lissue between August and September 1982.

5.5. The DANO's report, which was sent by the Chief Administrative Nursing Officer to the Chief Medical Officer and Chief Administrative Office in the Eastern Health and Social Services Board and arrangements, concluded that

> *"...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 for 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 children."*[69]

5.6. The contemporaneous records show that following discussion with Consultant Medical Staff, a change was made to the admission policy so as to ensure that children over 13 would not be admitted from 29 March 1983.[70] Additionally, measures were taken to restate all policies and procedures and discussion sessions were held with staff to reinforce their awareness of their roles and responsibilities.[71]

5.7. In the HSCB's submission, the DANO investigation and report correctly identified that the "*policies and systems*" in place Lissue in and around the time when LS 71 [LS 71] was an in patient [redacted]

[69] LIS 1421
[70] LIS 240
[71] LIS 1416

until the time of the investigation [redacted]) did not protect him. In her report, the DANO identified four possibilities for this, one of which was "*the more recent tendency to admit over 14-year-old children is stretching the Unit beyond that with which it can be excepted to cope.*"[72]

5.8. In the HSCB's submission, the admission of children over 14 years to Lissue is symptomatic of the very limited specialist resources available for adolescents in Northern Ireland with complex mental health and emotional needs, which is a matter the Inquiry has heard about in preceding Modules.

5.9. The HSCB considers, however, that the DANO investigation and report and, perhaps most importantly, the swift action taken on foot of it to adjust the admissions policy, demonstrate that its predecessor Board took appropriate steps in response to a very serious complaint and that there was a joined up approach between the medical and nursing professions.

Mental Health Commission Report (1987)

5.10. A report is available of the Mental Health Commission's visit to Lissue Hospital on 5 January 1987.[73] At that time, there were 17 patients in patients and 3 day patients.

5.11. The Mental Health Commission report confirms the existence of a multi-disciplinary approach in Lissue and that the Unit operated a key worker system to co-ordinate the individual patient's programme of care. The report also records that:

[72] LIS 1421
[73] LIS 13522. It is noteworthy that the report recommended regular visits in the future but no other reports have been found despite the service remaining on this site for a further two years.

a. Treatments that could be distressing for patients such as as Time Out and Behaviour Modification Programmes were carefully monitored and understood by staff.
b. Seclusion was not used in Lissue.
c. Some wards were lockable to keep children out at certain times and absconders were catered for by staff relocation.
d. Staff were given satisfactory training. The report states "nursing staff – 2 x ½ day study sessions. They can also attend training sessions run by the child psychiatrist for medical/nursing staff. Social workers – were given opportunity to attend training courses."

5.12. In the HSCB's submission, there is a strong parallel between the evidence given by former members of staff in Lissue and the recordings made in the Mental Health Commission report dated January 1987. In the HSCB's submission this demonstrates that weight should be given to the evidence of former staff members by the Inquiry.

National Board for Nursing, Midwifery and Health Visiting (1987)

5.13. Although the report has not yet been found, it is known through Minutes of the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland ("the National Board") that an Inspection of Lissue Hospital was undertaken by that Board in January 1987. The minutes 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 Hospital be approved for nurse training purposes.

5.14. The minutes also show that the National Board agreed that further consideration of the Child Psychiatry Unit at Lissue for approval for nurse training purposes would require a number of matters to be addressed,

including a review of the policies and procedures for the nursing management of the children with particular attention to the need for a philosophy on which to base nursing care; the need for the current pattern of excessive door locking; and the supervision of children who abscond from the Unit.[74]

5.15. On the evidence available, it is not known whether Lissue was re-inspected by the National Board and/or if it regained approval for nurse training before its closure in February 1989.[75] However, the documents show that on 8 April 1987[76] the Education Committee considered that their grave concerns should be drawn to the attention of the Area Board (the Eastern Health and Social Services Board) and their meeting on 9 December 1987[77] records receipt of a letter from the Chief Administrator, EHSSB and members noted that many of the items raised had been dealt with.

5.16. The National Board's withdrawal of approval for nurse training in 1987 is also referenced in an EHSSB memo dated 10 June 1988 from Ms. A Grant, Director of Nursing Services to Mr. R Lyons, Assistant Group Administrator in which Ms. Grant said:

"*The National Board Inspection of Jan/Feb 1987 withdrew approval as a nurse teaching unit as the philosophy of care was seen as restrictive and "custodial". The structure and layout of Lissue was not seen as well suited for its present use.*"[78]

5.17. In her evidence to the Inquiry on Day 200, Mary Hinds said:

"*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 …*

[74] LIS 1091
[75] Day 200, page 121
[76] LIS 1088
[77] LIS 1103
[78] LIS 226-227

the National Board seen practices that were inappropriate by way, for example, of restraint, I think they would have made mention of those…"

5.18. However, when Ms. Doherty pointed out certain likely limitations of the National Board's minutes, Mary Hinds agreed that the minutes could be read '*the other way round*" . When suggested to Mary Hinds by Ms Doherty that it would be a huge decision to remove nurse training approval, this was accepted.[79].

Stinson, Devlin & Jacob Review Reports (2009)

5.19. In 2008 allegations were made by LS 69 [LS 69] of abuse by a number of staff at Lissue Hospital. LS 69 had been an inpatient at Lissue during defined periods in [redacted] and [redacted]. She also had admissions to Forster Green Hospital for periods of time in [redacted] and [redacted]

5.20. Arising from these allegations, a complaint was made to police and a strategy meeting was held between Belfast Trust and the PSNI after which Belfast Trust submitted a Serious Adverse Incident report to the Department of Health and notified the Eastern Health and Social Service Board (EHSSB)[80].

5.21. Thereafter, Strategy Discussions took place involving the EHSSB, Belfast Health and Social Services Trust, South Eastern Health and Social Services Trust and the police. Among the decisions taken by the strategy group was that the EHSSB would take the lead on the investigation of historic complaints in Lissue and Forster Green Hospitals.

[79] Day 200, page 120, lines 8-17
[80] LIS 106

5.22. The process of the EHSSB's investigation of historic complaints in Lissue and Forster Green is set out in detail in the joint overview statement filed by the HSCB[81]. The resulting Historic Case Review report has become known as "the Stinson Report". However, in her statement to the Inquiry, Fionnuala McAndrew said that, as Mr. Stinson did not read full files but rather read selected extracts from files provided to him after an initial sift from a former librarian, it may have been clearer if the report had been entitled "An EHSSB Report in respect to Lissue and Forster Green Hospitals incorporating an independent view of historic cases."[82]

5.23. Whilst at this remove, it may appear a shortcoming that the review did not seek the views or contributions from former staff members, Ms. McAndrew's statement and evidence to the Inquiry explains that the review was a "*limited and immediate exercise*" which together with the Devlin and Jacobs review were designed to fulfil four objectives namely to:

a. Deal with concerns of a child protection nature;
b. Make sure that anything which offences of a criminal nature were appropriately dealt with;
c. Take appropriate action if there were any issues concerning staff still employed in the system; and
d. Make sure that the current care of children in a similar facility as appropriate.[83]

5.24. Acting in her capacity as the Director of Social Services of the HSCB, Ms. McAndrew reported to the Board[84] and the Department[85] about the outcome of the review process and said, *inter alia*, "[*i*]*t is also clear that children accommodated within these hospitals were subjected to a harsh and*

[81] LIS 109 - 110, paragraph 104
[82] LIS 1438, Statement of Fionnuala McAndrew dated 22 April 2016, paragraph 8
[83] LIS 10261-10263
[84] LIS 13714 (Folio 21)
[85] LIS 11992

punitive regime".[86]

5.25. In her evidence to the Inquiry, Ms. McAndrew said that in so reporting she drew from the Stinson, Devlin and Jacobs commentary and her reports were made '*in the context of the issues that were raised in the small sample size*'[87] to people who were aware of the context in which her reports were being made[88]. However, Ms. McAndrew also accepted that, with hindsight, "*it would have been clearer to have said that it was specifically in respect of the children within the context of the sampling exercise and I accept that now.*"[89]

5.26. This is important because in accepting the recommendations of the review reports, the HSCB was not intending to comment upon the institution as a whole and, as Ms. McAndrew made clear in her evidence, the review reports should not be interpreted "*as an indictment on the wider system within Lissue, and certainly it was never the intention that that was what should happen, or to make comment on the wider group of staff who were employed in Lissue. It was specific to the staff mentioned in any of the records.*"[90]

5.27. Ms. McAndrew was equally clear, however, that there was was concern about some of the entries in the records extracted for the Stinson review and, "*notwithstanding the limitation of the sample size, there were still issues that were highlighted by the professional reviewers that did cause them professional concern.*"[91]

5.28. This was confirmed by Ms. McAndrew during the following exchange with Ms. Doherty on Day 203:

[86] Ibid
[87] Day 203, page 10, lines 13-16
[88] Day 203, page 12, lines 15-20
[89] Day 203, page 17, lines 10-16.
[90] Day 203, page 13, lines 22-25 and page 14, lines 1-2.
[91] Day 203, Page 10, lines 12-16

"Q.…[L]booking at the three reports and accepting the very focused nature of them and the extracts, they do raise quite significant issues about the care that was provided, the use of restraint, how responding to sexual behaviour between children, and rough handling by staff…what I want to be clear about is you are saying in your report now, looking back, talking about a harsh and punitive regime on the basis of those reports was maybe a step too far, but are you standing away at all from the notion that there were issues to be looked at more generally in Lissue? A. No, I am absolutely not, and I think that is a balance in terms of the evidence that you have heard. The reviewers in their reports were very specific about their concerns about entries in the file. Now it may be, if there had been a wider review, that further understanding of some of those actions could be achieved [but]… as a professional social worker… I would have concerns that some of the entries did give rise to concern about individual practice that those children in the sample experienced."[92]

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5.29. In respect of the children in the sample, the HSCB also notes that of the file extracts reviewed by Mr Stinson, there are 10 children about whom no concerns were identified in any area of their care[93].

Concluding Remarks

5.30. In conclusion, therefore, the HSCB considers that the available evidence in Module 13 does not support a view that the practices in Lissue as a whole were harsh and punitive. The HSB believes that such a view would ignore vital contextual factors about medical treatment and care.

5.31. Having reflected on all the available evidence, however, including the review reports, the HSCB is of the view that, in some instances, the care delivered to individual children in Lissue may have fallen below the expected standards, in particular as regards the practices of time out,

[92] This is an edited extract, for the full answer please see Day 203, Page 24, line 12 to Page 25, line 17
[93] LIS 10980, Children C, F, G, L, N, O, Q, V, X and HH

restraint and the treatment of HIA 3 by staff as detailed in Chapter 3 However, the Board is also mindful that the Inquiry has only heard from a very small proportion of children who were cared for in Lissue and that the Review reports considered a relatively small sample of file extracts.

5.32. The HSCB suggests that the evidence in relation to behaviour modification programmes in Lissue, indicates that whilst some Applicants perceived them as harsh, the witnesses from the multi-disciplinary group all believed that they produced appropriate results in modifying difficult behaviour in children. There has also been evidence of a spectrum of practice employed by staff in Lissue Hospital. Some staff were considered to be stricter, while others adopted a more caring, compassionate approach . This will inevitably have resulted in the different implementation of techniques. The HSCB does not however accept that the evidence in this Module amounts to systematic abuse of children.